Maternal and Child Health Services
Title V Block Grant

State Narrative for Marshall Islands

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The RMI will comply with the Assurances and Certifications as stated. The appropriate Assurances and Certifications--non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke--that accompany this guidance can be access from the the guidance in the State's MCH program's central office.
/2010/ No change. //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Means of Public Awareness:
The Ministry of Health has put more effort to have the public be more involved in the MCH programs and reviewing of the grant application. For FY 2010, public announcements were made for the public for any comments and input regarding any issues in the grant application. Copies of the MCH Block Grant Application were made available at the MCH office at the Ministry, including other information that any interested person (s) may wish to comment/input regarding the grant application. In addition to this, distribution of the draft report for comment on the report and to hear additional views (by phone-calls/writing/other means of communication) regarding the RMI MCH Block Grant Application for the FY 2010.

The government radio station (V7AB) broadcasted the announcement where most of the people especially in the outer islands have access to it. They can hear the announcement that is aired from 6:00AM to 11:30 PM/ 7 days a week. Public announcement is also made during the Council of Children with Special Health Care and Education Needs meeting twice annually. Furthermore, where to call for more information was provided to the public. For more information concerning the application, please call MCH program at the Ministry of Health: (692) 625-3355 (Ex.: 2123)/625 7007/455-8334; or visit the MCH office during regular working hours (Monday through Friday)/ (8:00 am to 5:00 pm).

Public Comments/Questions:
The public made comments on Component C, Children with Special Health Care Needs. Because most families can't afford the cost of medical bills, they asked if the services for the CSHCN are free. Some patients and care takers expressed their concern regarding cost of the medical equipments and supplies needed for these children in their daily use, such as glasses, hearing aids, wheel chairs, etc... They also expressed the need for the service providers to make more home visits or on a regular basis. Parents think that the services provided are not enough. Parents ask to increase the number of staff providing the direct services for the CSHCN.

/2010/ Public comments/questions:
The public, specifically the parents, presented their comments and questions concerning CSHCN services. They would like to see in the future consultants /doctors who could come to RMI to provide special services/care, such as cardiac service, hearing problems screening, eye screening, and other services for disabled conditions. For those with children with mental delay and unable to move one part or the whole body, special providers is needed. They think that short term service and doctors should be provided to the children where it is needed. They commented to hire service coordinator, including at least one staff so that they could spend more time in providing the care that is really needed for the clients, such as, counseling and training the parents/care takers on helping their children to be able do something in their lives. Parents need someone that has more time to train them on how to be more effective as parents to take care of their children with special health care needs. Some of the children can't move without assistance, family can't afford to pay for the equipments needed to help their children. In the next 5 years Need Assessment, the concerns of the public and parents will be addressed again. We are hoping to make things better. //2010//

Responses:
For the children whose families can't afford the hospital fee of $5.00 per visit to seek medical care, especially those coming from the outer islands, the program is billed with the required hospital fee. The program has taken steps in strengthening the collaboration between the program and departments within the Ministry and other government ministries for better utilization of equipments for those children in need, such as, wheel chairs for example. The MCH program has also made arrangement with the medical record to submit CSHCN's outpatient service cost on monthly basis. The program will take care of the charges. The program has also provided medical equipments for the CSHCN who are in need with no means of paying, for example, wheel chair.
The program continues to seek assistance from other service agencies, for example hearing aids, glasses, and others.

An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2009/ During the year, the process of reviewing data and assessing the programs and services within the Ministry continued. The Office of Health Planning continued to provide data on all RH/MCH programs and services for the senior staff. During the review and recommendations, it shows that there is a need to update the goals and interventions of the MOH. Furthermore, community participation and preventive health services are recommended in order to carry out the goals and reach all population groups including the MCH's population.

//2009//The Ministry of Health continues to review data and assess the needs all year around. Steps have been taken to ensure that data requirements in the MCH Block Grant and the Ministry are met. The new Ministry of Health's Integrated Information System (MHIIS) is soon to be completed. We are looking forward in generating more accurate data from the new information system. While we are waiting for the new information system to be implemented, we continue to use old information system.

/2010/ There was no formal Needs Assessment conducted to evaluate the service provided to the MCH population. However, based on an assessment conducted by the MOH utilizing data from the Health Planning and Statistics Office, i tis clear that MCH service and primary health care services must be further improved in order to improve the health status of the MCH population. Survies were done and analyized. Based on the results, the RMI has selected the same state "Negotiated" Measures that will address the four layers of the pyramid, namely direct health care services, inabling services, popualtion-based services and infrastructure building services. Additionally, the selected "negotiated" measures will further support the Core Public Health Services outcome measures.

For the RMI MCH Up-coming Needs Assessment, the plan will for MOH with KUMITI Committe with coordinate with the National Planning (EPPSO) to review the both Health Informaito System and the RMI National Census. The population servey has just been done lately, with survey, and other machinism being used to obtained the Natioal Censues.

Our biggest challange is our new Inforamtio System (MHIIS) is still in progress. We are targeting to complete the implementation by 2010.We have implemented some of the modules. The Public Health Information System under the umbrella of MHIIS, where in Reproductive Health Module is included, is expected to be completed by 2010. The MCH program continues to receive data from the MOH Health Information System that the MOH has been using. Updates will be used to make appropriate adjustments in activities such as plan development, funding, quality assurance and standards development. Updates will also be used for reporting and budget development. The MHIIS will allow in-depth and quality data.

There is a plan to bring the new system in the Ebeye Hospital after the completion of implementation in Majuro. For 2010, we will be working on the plan. //2010//

III. State Overview

A. Overview

/2010/ In the fifty years since the end of World War II, two principle trends have occurred in the population of the Marshall Islands: rapid growth and continuing urbanization. The Marshall Islands has a very young growth population. With somewhat more than 30% of the Marshallese, people live in a semi-subsistence mode in the rural atolls and islands of the nation. The majority of the population lives in Majuro and Ebeye.
/2008//No change//2008//
/2009/No change.//2009//
/ 2010/ No change. //2010//

/2010/ The Republic of the Marshall Islands is situated in the Central Pacific Ocean between 4 degrees and 14 degrees North and 160 degrees and 173 degrees East in almost two parallel chains of 31 Atolls and Islands. The Eastern Ratak (Sunrise) with 15 Atolls and Islands and the Western Ralik (Sunset) having 16 Atolls and Islands. The total number of islands and islets is about 1,225. No change.//2008 //2010/////
/2009/No change.//2009//
/2010/ No change. //2010//

/2010/ Each atoll consists of a ring of islets encircling a deep water lagoon. The islets are interconnected and surrounded by a coral reef. None of these low-lying land areas have an elevation greater than ten feet above sea level. Two of the atolls--Majuro and Kwajalein--have become crowded urban centers. while the outer atolls remain rural in character and are known as "outer islands." No change.//2008// //2010//12009/No change.//2009//
/2010/ No change. //2010//

Ebeye, a small island within Kwajalein Atoll, is the only ***/2010/ Majuro Atoll is the most highly developed area in the nation and has several high schools, a community college, an 80 bed hospital and a developing infrastructure of electrical distribution, fresh water reservoirs and sewerage disposal. The atoll is thirty miles long. The widest islet measures about half a mile from ocean to lagoon. As the national capital, Majuro is home to an expanding population, estimated to be 61,215 at projected population 2004, and is the site of most public, commercial and industrial development. With a land area of 3.75 square miles, Majuro Atoll has a population density of 29,488. Much of the population is crowded into the " downtown" administrative and commercial center at the eastern end of the atoll. No change.//2008//***
/2010/ No change. //2010//

/2009/No change.//2009//No change.***/2010// //2010//***other urban center in the Marshall Islands. The urbanization of Ebeye commenced in the late 1940s with the Department of Defense, with the relocation of Marshallese people from northern atolls that where affected by the US Nuclear Testing Program (1946-1958) and with 1964 opening of the Kwajalein missile testing range by the US Army. With commencement of the missile testing program, families living in the central area of Kwajalein Atoll --known as the Mid-Atoll Corrideor--were relocated to Ebeye. In addition to its high birth rate, the population of Ebeye continued to grow over the years as people from throughout the Marshall Islands (and elsewhere in Micronesia/other countries) were attracted to job opportunities at the nearby military base. On Ebeye Island, more that 11,000 people reside on a land area of .12 square mile. Housing substandard and extremely crowded. While a new 38 bed hospital, currently opened that replace a dilapidated older facility, health problems are numerous and may be attributed, in part, to overcrowding and an inadequate water supply. Kwajalein Atoll is the largest atoll in the world, with a lagoon area of 839.3 squares miles. The total land area of the Kwajalein islets comes to 6.33 square miles. No change.//2007//
/2009/No change.//2009//

/2010/ No change. //2010//

The rural outer islands comprise the remainder of the Marshall Islands/ Scattered over great expanses of the Pacific Ocean, population in separate communities range from 50 to 800 persons. The outer islands constitute a diminishing proportion of the population of the nation. With few exceptions, between noncontiguous islets of an atoll can only be taken by canoe or motorboat/ Meals are cooked on open fires or single-burner kerosene stoves. The government field trip ships travel to each outer island every two ot three months bringing passengers, medical and education supplies and trade goods. Income for residents of the outer atolls is generated primary from the sale of copra (dried coconut) and handicrafts. No change.//2008//
/200/No change.//2009//
/2010/ No change. //2010//

In the outer islands, medical care is available at dispensaries staffed by health assistants who maintain radio contact with the Majuro or Ebeye hospitals for instruction and guidance. Other than a public school on Jaluit Atoll, another public school completed at Wotje Atoll and a private, church-affiliated high school at Ailinglaplap Atoll. there are no secondary education facilities in the outer islands. No change.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

Each of the twenty-four inhabited outer islands has an airstrip. Several of the lager atolls have more than one airstrips. Emergency medical evaluation are accomplished by small and lager aircraft or, at islands where the airstrips have been closed for repair, by field trip ship. Medical evacuation by aie can only take place by daylight since the outer island airstrips do not have landing lights. Medial evacuation by ship to the hospitals in Majuro or Ebeye can take as long as two days, depending upon distance and sea conditions. Patients in the outer islands requiring specialized care not available at Majuro or Ebeye would be routed through Majuro or Ebeye before referral to Honolulu.The outer island dispensaries and the hospitals at Majuro and Ebeye are owned and operated by the RMI Ministry of Health. There are no private health care providers in the Marshall Islands.
No change.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

People travel from Majuro and Ebeye to the outer atolls on a 24-Seat Dornier managed the Air Marshall Islands an don government-owned field trip ships that commute between atolls once a month. A small boat that is highly dependent on fuel supplies, available, people walk during low tides on the exposed coral reefs between the islands in order to reach the airstrips. It takes more than 24 hours to travel by ships and more than an hour and half by plane to the farthest island.
No change.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

The total population of the Marshall Islands is estimated at 63,579. More that 50% of the population is under 15 years of age. The average growth rate of 3.6% is the highest in the Pacific. Currently, more than 60% of the population resides in the two urban centers. The remaining 40% reside in the outer atolls. Delivery of health care services to a dispersed population in the RMI is cumbersome.
/2007/The projected population of the Marshall Islands is slightly increasing. In 2006, the projected population has increase from 63,579 to 65,814.//2008//
/2010/ No change. //2010//

/2009/ Migration has the biggest impact on contemporary population growth in the RMI, as we can see from international migration statistics for the RMI, 1990 - 2006, that recently became available, and which have not factored into any projections in the 1990s. this is the sole reason

our projections provide you with a RMI population total of around 52,338 - which is considerably lower than he figures of 62,000 currently floating about. We have used an annual net migration total of - 1,500 for 1999-2001, and then dropping it to -850, which corresponds to the annual net migration total between 2002 - 2006. A new projected population was released by the Economic Population, Planning, and Statistics Office in 2008.//2009//
/2010/ No change. //2010//

B. Agency Capacity

/2010/ The Constitution of the Marshall Islands designates the Ministry of Health and Environment (MOHE) as the "state" health agency. The MOHE is the only legislative authorized agency that provides health care services to the people of the Marshall Islands. /2007/ The Ministry of Health and Environment (MOHE) has changed. MOHE is now Ministry of Health (MOH). This was done to transfer Environment programs from the Ministry to RMI Environment Protection Agency (RMI EPA). This has allowed more public access to information and better coordination and collaboration between MOH and EPA in terms of cleaner and healthier environment.
No chnage.//2008///2009/No change.//
/2010/ No change. //2010//

The Bureau of Primary Health Care (PHC) is one of the five major bureaus within the Ministry of Health. It is reponsible for all preventive and primary care and the Division of Public Health is one of the five and the largest with five program areas. No change.//2007//
/2009/There are three Bureaus that provide direct health care services in the country: 1) The Bureau of Majuro Atoll Health Care Services (MAHCS), 2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS), and 3) The Bureau of Outer Islands Health care (OIHCS). In each bureau, there is a Division of Primary Health Care. The DPHC in each bureau will handle the preventive and primary health care services to the population covered by the Bureau.//2009//
The MCH/CSHCN Program is not a separate agency. It is one of the programs in each bureau under the Division of Primary Health Care. With this organization lay out, the MCH program in KAHCS and OIHCS coordiante and submit report to the main MCH program which is in Majuro. The nurses and medical staff implement all clinical, follow-up and community outreach programs for all areas in Public Health. The MCH/CSHCN Program provide health care services for mothers, children, infant,adolescents and their families in the RMI. There are currentlt 22 nurses who implement all clinical services for public health programs, seven medexes (physicial assistants), a medical director and an OB-GYN who are assigned to Public Health.
Seven (7) of the public health staff receives support salaries from the MCH Block Grant. The same seven staff (nurses, medexes/physicians) also travel to the outer atoll to implement the programs and services in Public Health. No change.//2007//
No changed.//2008//

/2009/The MCH/CSHCN is one the components within Reproductive Health. There are eight nurses, three OBGYNs, and five support staff receiving salaries from the program.//2009//
/2010/ No change. //2010//

Oral Health is being one of the MCH/CSHCN program services that receive support from the MCH program in terms of services for pregnant women and children, including the schools and all MCH population. Due to shortage of trained dental health care providers, the MCH/CSHCN program is in the process of hireing two additional dental assistant to assit in the MCH dental sercvices, and to expand its services into the communities.
No change.//2008
/2009/Hiring of two dental providers have been implemented, and more out reach activities into the schools and into the communities are going on.//2009//

The overall health care system in the Republic consists of two hospitals in the two "urban" centers of Majuro and Ebeye, and 57 health centers in the outer atolls. The main hospital on majuro is a 80-bed facility, and Ebeye has a 25-bed hospital. Both facilities mainly provide primary and secondary care with very limited tertary care. Patients who need tertiary care are referred to hospital in Honolulu or the Philippines. The Bureau of Primary Health Care within the Ministry of Health also offers a full range of preventive and primary care programs in the two main hospitals.
No change.//2008//
/2009/No change//2009//
/2010/ No change. //2010//

The MCH and CSHCN have been intergrated into one program. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH. The RMI MCH/CSHCN program provides and coordinates the full spectrum of preventive and primary health care services for mothers, infants, children and adolescents both in the hospitals setting and the health centers. The services include prenatal and high-risk prenatal care clinics, postpartum care, and well childcare that includes immunization, high-risk pediatric clinics, school health program, coordination of family planning services, and the coordination of care for children with special health care needs.
No change.//2007//
No changed.//2008//
/2009/MCH/CSHCN have been placed within Repriducitve Health. This further allows for more efficient use of scarce human resources and better collaboration and coordination of services in MCH.//2009//
/2010/ No change. //2010//
For several years, one of the priorities of the MOH was to develop an effective health information system. The Ministry is currently hired a new Health Planner. The Ministry has received technical assistance to modify its Health Management Information System (HMIS) in order to improve its capabilities to collect and use data to improve health care services. The Ministry has established a HMIS Committee and Working Group to review all forms and other documents that will enhance the HMIS. All programs in the Ministry have already started using the revised forms for recording and reporting of data which are being collected and channeled to the Bureau of Health Planning and Statistics. Staff training on the use of the revised froms is completed.
No change.//2007//
No cahnged.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

While data and information systems have improved in the past year, this improvement has occurred primary within the urban health care settings. There is still a need to improve the data collection from the health centers int he outer atolls. The HMIS Committee has revised the recording/reporting froms, which will enable the health providers in the health centers to collect essential data and statistics. In addition to the encounter forms used by health facilities in the urban centers, a monthly form was developed to ensure that reports are regularly submittedf to the Office of Outer Islands as underreported by agencies within the Government due to inadequacy of reports submitted from the health centers. Therefore, mechanisms have been developed to improve the reporting of the number of births, deaths and encounters for all clinical and preventive services provided in the outer atolls.
No change.//2007//

/2010/ Up-date, a new data and information system is almost done where all data computers will be link for access data more easily when needed from other programs within the Ministry of Health. While the new informaion is still not completed yet, the MOH continues to use the previous sysytem which is a computerized database. Therefore, still the MOH is able to access data on Maternal and Child Health for program use purposes

//2010//.

The Health Management Information System (HMIS)

The HMIS is a computerized database to handle all health and health-related data in the MOH. Based on the File Maker Pro sofware, it was designed to be a user friendly and menu diven system that can be used to monitor the progress of various health program, meet the reporting requirements of US Federal Grants, WHO, and other external agencies.
No change.//2007//
/2010/ No change. //2010//

/2008/Health Mangangement Information System is on the way for completion.
/2009/The new Health Manangement Information System is almost done.//2009//
/2010/ In 2006, the Ministry of Health acquired a customized system for the Ministry and named it as Ministry of Health Integrated Information System. Initally, the system comprises of Vital Records Information System, Hospital Information System, Public Health Information System, and Management Information System. For the 1st phase of the system, the target is to implement in Majuro. Upon completion, we will expand to Ebeye and Outer Islands. Although our overall progress is 20% on the new system, we have our old systems in Majuro, Ebeye, and Outer Islands that captures the daily activities of the Ministry. We are looking forward to 100% implementation in Majuro by next year.

In 2008, a new system was added to the our Integrated System. We started then development of Medical Referral Information System. We added this system to the existing contract to upgrade our existng medical referral access system. In 2009, we implemented the system and received a good review. The system aims to record the transactions in patient care and financial of the RMI Medical Referral to Honolulu, Manila, and Taiwan.//2010//

The HMIS has four goals that aim to meet the information needs in the RMI. The first goal is to support the expand role of Primary Health Care. The Ministry believes that by implementing a wide range of effective and sustainable PHC programs, we can significantly reduce disease burden. Therefore data management and monitoring PHC is critical. The second goal is to provide accurate, consistent, and timely reports on the broad range of health services and programs offered by the MOH. These reports can also assist health manangers in decision making. The third goal is to provide the MOH with a wider range of information on the personnel and financial resources that are available. This will assist in the health planning for the future. The fourth goal is to ensure that the HMIS is a sustainable system that can be used to provide timely and accurate data for managers tasked with policy making decisions.
No change.//2007//
No change.//2008//
/2009/No change.//2009/
/2010/ The New Health Information System will be continued with the same goals stated above. //2010//

The HMIS database is divided into five modules: Medical Records, Public Health and Epidemiology, Referrals, Finance and Personnel, and Benefits, Monitoring and Evaluation (BME).

The main purpose of the Medical Records modules is to accurately record a patient's life and medical history. This information will be useful for clinical providers in treating the patients and to health service managers responsible for health planning, supervision and evaluation of health services.
No change.//2007//
No change.//2008//
/2010/ There are 5 systems comprising the Ministry of Health Integrated Information System. They are Vital Records Information System, Hospital Information System, Public

Health Information System, Management Information System, and Medical Referral Information System. //2010//

1. Medical Records

The main focus of HMIS activities so far has been on the Medical Records component since it was where most of the data collected had to be consistent and able to accommodate all the curative and preventive care departments who see patients.
No change.//2007//
/2008/ It will be shifting to the new Information System.
/2009/No change.//2009//
/2010/ No change. //2010//
Therefore, a comprehensive encounter form was developed.

The Encounter Form

The Outpatient encounter form contains the patient's name, medical record number, encounter date, date of birth, age gender, atoll of residence, type of visit, and the health provider's name. A list of diseases classified by their International Classification of Diseases 9th Edition (ICD-9) codes, procedures, and referal destinations are listed in boxes for the health provider to complete.
No change.//2007//
/2009/No change.//2009//
/2010/ It is still being used. //2010//

The encounter form was originally designed for the hospital's outpatient activities. In collaboration with the HMIS Working Group, which comprised of the Secretary of MOHE, the Assistant Secretary, PHC, and various departments and programs directors, the original encounter form was modified and the name changed to "MOHE Encounter Gorm" to reflect the number of departments for which this form was redesigned. While it resembles the format of the original for, there have been numerous changes and modifications. The International Classification of Diseases,9th Edition (ICD-9) was used to standardize and classify patient findings. Sections of the form have also been rearranged to address the needs of each department.
No change.//2007//
No change.//2008
/2009/No change.//2009//
/2010/ No change. //2010//

/2010/ The encounter form is still being used. //2010//
The MOH Encounter Form is used in the Majuro Hospital, Ebeye Hospital and Outer Islands Health Centers and complemented with a monthly report form to be sent to majuro each month by the Health Assistants. The MOH Encounter already includes catregories related to cancer screening and treatment. Combined with the patient's medical chart, the Encounter Form will assist both the clinican and the Ministry's data management and surveilance efforts.
No change.//2007//
No change.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

Public Health and Epidemiology

The Public Health and Epidemiology components do not have a starndard form (excluding those for Births and Deaths) and relies on the monthly reports sent by each department to the Planning Office. While some data can be obtained from the Planning Office, a form, which lists specific data categories, was designed for selected public health departments. This format will enhance monthly data reproting to the Planning Office and provide HMIS with the necessary information to

assist in documenting vital and other health-related statistics. The data will enchance the data collected from public health and medical records. As part of the cancer screening and early detection program coordinator's duties, a monthly report will be sent to the Office of Planning and Statistics to ensure that the data is collected and appropriately disseminated.
No change.//2007//
No change.//2008
/2009/No change.//2009//
/2010/ No change. //2010//
The Referral component will be essential to determining the incurred costs for overseas referrals. Like the MOH Encounter Form, patient information will also be included. The modules primary objectives are to document the amount spent on each type of referral. The patient and financial information can be used for long term planning. Through this module, the number of cancer related referrals to tertiary hospitals in the Philippines or Honolulu and cancer related deaths that occur overseas are documented.
No change.//2007//
/2009/No change.//2009//

Finance and Personnel

The Finance and Personnel Module was designed to provide the MOHE with a system that identifies financial information available and utilized by the Ministry. A Five-Year Budjet Planning Model and Program Budget Allocation Program designed with the assistance of MOH staff is being implemented to ensure that the services we provide are sustainable.
No change.//2007//
No change.//2008//
/2009/No chnage.//2009//

Benefits, Monitoring, and Evaluation (BME)

The objective of the BME module is to ensure the accuracy and relaevance of the data we generate. In addition, the module is intended to provide a series of indicators to monitor and evaluate the efforts undertaken by MOH staff. We will be able to see which health programs or services have had the most impact and which needs refinements.
No change.//2007//
No change.//2008//
/2009/No change.//2009//

Training and Professional Development

The ministry and donor agencies fund the continuing education and training of public health staff. The assistant secreatry or program directors assisgnment the personnel who attend training program. The training has been in various formats like workshops, seminars, and dertificate programs or academic programs.
No change.//2007//
/2009/No change.//2009//
/2010/ Still receives support from ministry and donor agencies fund. //2010//

Evaluation Plan

Monitoring and evaluation duties will be assigned to the individual program managers and directors and to the Bureau of Health Planning and Statistics. In the process of monitoring and evaluating the implementation of activities for the grant, the Health Management Information System is being tailored to address the needs of a database that will be flexible to collect epidemiological data that can be used as a tool for investigations and policy making decisions. Monthly reports from the various programs will provide sifnificant data on the health services being provided and the types of cases seen in the clinical and public health offices. Data such as

morbidity and mortality number of cases seen involving fever, cases of diarrhea, number of chronic diseases like high blood pressure and diabetes will assist the Bureau of Health Planning and Statistics in identifying potential contributors to an outbreak. Preventive measures can then be taken to minimize the number of cases.
No change.//2007//
nO CHANGE.//2008
/2009/No chnage.//2009//
/2010/ On going. //2010//

A formal evaluation will be done throught the HMIS's Benefits, Monitoring and Evaluation module (BME). This module will compement other evaluation and monitoring tools that may be proposed by the Ministry's technical committee. The following table lists some of the measures that will be included in the BME.
No change.//2007//
nO CHANGE.//2008
/2009/No change.//2009//
/2010/ This is done on an annually basis. //2010//

These measures were selected to assist the Secretary of Health, Assistant Secretaries, department managers, program coordinators, and the Health Planning and Statistics Bureau in developing contingency, staffing, and organizational plans to ensure that the MOH will have the means to collect and analyze data for tracking the National and Jurisdicational performance Measures.
No change.//2007//
nO CHANGE.//2008//
/2009/No chnage.//2009//
/2010/ Monitoring and Evaluation are being done using outcome from data. //2010//

C. Organizational Structure

The Government of the Marshall Islands is a parliamentary system. Thirty-three senators are elected to the Nitijela (congress) every four years, and from the Nitijela, a president is elected. The Presidential-appointed members of the Cabinet exercise all executive functions of the Government of the Marshall Islands. The Ministry of Health (MOH) is one of nine governmental agencies instituted under the Government of the Marshall Islands.
No change.//2007//
No CHANGE.//2008//
/2009/No change.//
/2010/ No change. //2010//

The head of the MOH is an elected senator and a member of the President's Cabinet.
The Minister exercises authority for health on behalf of the Cabinet, and he/she is responsible for the development of policies for the Ministry with recommendations from the Secretary of Health, on the other hand, is appointed as the "permanent" head of the Ministry. The Secretary of Health is responsible for daily management and administration of the Ministry and reports directly to the Minister of Health.
No change.//2007//
No change.//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

The MOH has five major Bureaus:

1. Bureau of Primary Health Care
2. Bureau of Majuro Hospital Services

3. Bureau of Health Planning and Statistics
4. Bureau of Kwajalein Atoll Health Care Services
5. Bureau of Administration, Personnel and Finance

/2008/
The MOH has Three Bureaus and 3 Major Offices:
1) The Bureau of Majuro Atoll Health Care Services (MAHCS),
2) The Bureau of Kwajalein Atoll Health Care Services (KAHCS),
3) The Bureau of Outer Islands Health Care Services (OIHCS),
4) Office of Administration, Personnel and Finance
5) Office of Health Planning and Statistics
6) Office of Medical Referral Services.//2009//
/2010/ No change. //2010//

With the exception of the Office of Health Planning and Statistics which is headed by the Health Planner, an Assistant Secretary heads each bureau. All Assistant Secretaries and the Health Planner report directly to the Secretary of Health.
/2009/The Health Planner was transferred to Ministry of Internal Affairs to be the Secretary of the Ministry. No new Health Planner yet.//2009//
/2010/ No change. Hiring of Health Planner is in the process. //2010//

The Bureau of Primary Health Care where the MCH program and CSHCN program is based, is further divided into six divisions:

1. Division of Public Health
2. Division of Human Services
3. Division of Population, Family Health & Health Promotion
4. Division of Reproductive Health (MCH/CSHCN/Family Planning/Adolescent Health)
5. Division of Outer Islands Health Centers
6. Division of Dental Services

/2010/ Each bureau have the Division of Primary Health Care. The objective is to better serve the population covered by each bureau on their primary health care needs. //2010//

/2010/ Bureau of Majuro Atoll Health Care Services is composed of 6 divisions:
1. Division of Ancillary Services
2. Division of Primary Health Care
3. Division of Clinical Services
4. Division of Nursing Services
5. Division of Support Services
6. Division of Health Information and Management

Bureau of Kwajalein Atoll Health Care Services is composed of 4 divisions:
1. Division of Curative Services
2. Division of Health Management Information system
3. Division of Primary Health Care
4. Division of Support Services

Bureau of Outer Islands Health Care Services is composed of 2 divisions:
1. Division of Clinical and Training
2. Division of Primary Health Care //2010//

A director who reports directly to the Assistant Secretary for Primary Health Care heads each of the division. In the Division of Public Health, there are four program areas in which the MCH/CSHCN program is one. The Assistant Secretary for PHC is responsible for the daily

management and supervision of programs carried out under the Title V program in each of the divisions.
No change.//2007//

/2010/ The DPHC director reports directly to the Assistant Secretary of the bureau. Each bureau has a division of primary health care. One of the services under DPHC is the Reproductive Health Clinic. Reproductive Health Clinic (RHC) handles the MCH/CSHCN program. Between the bureaus, MHACS' MCH/CSHCN program work as the main contact point, provides the funding, plans the program's activities, and apply, supervise, and reports the grants. The Director of RHC in MHACS collaborates and coordinates the activities. The staffs of RHC in MHACS are also the staff of RHC in OIHCS.

The Assistant Secretaries are responsible in the management and supervision of programs within their bureau. //2010//

In the Reproductive Health Clinic, there are three programs which are MCH/CSHCN, Adolescent Health, and Family Planning. //2008//

/2008/Maternal and Child Health/Children with Special Health Care Needs/Family Planning/Adolescent Health have been integrated into one Division, which is now called the Reproductive Health Clinic, which is under the Division of Primary Health Care. This allows for more efficient use of scarce human resources and better collaboration and coordination of services in both programs.
/2009/No change.//2009//

/2010/ Adolescent Reproductive Health has merged out into Youth to Youth In Health Program which is an NGO. The purpose is to allow more efficient use of scarce human resources and better collaboration and coordination of services in between Youth to Youth In Health and Reproductive Health at the Ministry of Health. //2010//

An attachment is included in this section.

D. Other MCH Capacity

Twenty-two nurses in Public Health implement all the clinical and primary health care for all program areas in Public Health. These same nurses travel to the outer islands in addition to supervising their assigned health zone in Majuro. The nurses must also work on weekends to do cold chain monitoring for vaccines stored in the Public Health clinics and to immunize all new-born babies in the Majuro Hospital with BCG and Hepatitis B vaccines when necessary. The nurses are not compensated for the times they work during weekends. Furthermore, the nurses are the only ones trained in the cold chain monitoring of the vaccines and are responsible for packing them to be sent to the outer atolls on weekends. Seven of the public health staff (nurses,medexes/physicians/dental assistants/health educators) receives support salaries from the MCH Block Grant. These same 7 health care providers provide the service delivery to the MCH population throughout the Republic.
//2009//Three additional Reproductive Health (RH) Nursing staff have been hired and this makes it to 10 nurses providing direct Reproductive Health Services for Majuro and outer islands as well as providing staff support for Ebeye RH service delivery. /2009/
Six providers receive salaries from the MCH Block Grant (MCH OBGYN, Health Educator, Dental Assistant, Nurses). The rest of the program providers receive salaries from other funding. Other funding sources are, UNFPA, and Title X/Family Planning.
/2010/ No change //2010//.

E. State Agency Coordination

The Ministry of Health and Environment, being the only "state" agency that provides health care services in the Republic, realizes the significance of collaborating with other agencies in the implementation of services to the communities./2007/ Change from Ministry of Health and Environment (MOHE) to Ministry of Health (MOH).//2008//
/2009/No change.//2009//
/2010/ No change. //2010//

Since the MCH/CSHCN is one of the programs in Public Health, services are effectively coordinated among the staff in Public Health, who also provides services for other program areas. The MCH/CSHCN program also coordinates with other divisions in the Bureau of Primary Health Care, such as the Mental Health Program, Alcohol & Substance Abuse Prevention Program, Vocational Rehabilitation and Social Work. For community outreach purposes, MCH/CSHCN coordinates with the Health Education and Promotion Unit,the Nutrition Unit and the Family Planning Program. These services have been expanded that other programs provide services to the MCH/CSHCN population have included.
No change.//2007//
/2009/The MCH/CSHCN is one of the programs under the Reproductive Health Clinic (RHC). Services are effectively coordinated among the staff in Reproductive Health.//2009//
/2010/ No change. //2010//

//2009//The MCH/CSHCN and Family Planning have integrated into one services which is the Reproductive Health for better utilization of services. RHC has expanded its service delivery with two additional clinics sites on Majuro, Laura Health Center and Youth to Youth In Health clinics. Coordination and collaboration between RH and other programs and agencies are all on-going.
/2010/ No change. //2010//

The MCH/CSHCN coordinator is also a member of the Inter-Agency Leadership Council which coordinates with all agencies that provide services for children with special health care needs. Through a Memorandum of Understanding, the members of the Inter-Agency coordinate services for all CSHCN and adults who have special needs. The members of the Inter-Agency Council include: Special Education Program in the Ministry of Education, Health Start Program, College of Marshall Islands, Majuro Atoll Local Government, Kwajalein Atoll Local Government, Women in Development Office in the Ministry of Internal Affairs, and the programs in the Ministry of Health such as the Mental Health Program, Vocational Rehabilitation and Social Work. This Inter-Agency meets on a quarterly basis.
No change.//2007//
/2009/No change.//2009//
/2010/ No change. //2010//

The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs. The MCH Coordinator chairs the Core Committee with other member from Nutrition Program, Hospital Services, Adolescent health, Health Promotion, Family Planning and the Human Services programs. All the international and national health events are coordinated by the Ministry's Core Committee in collaboration with the RMI Inter-Agency Council and the National Population Coordinating Committee. The Core Committee in the MOH carries out coordination of community awareness on primary health care activities and programs.
No change.//2007//
/2009/ No change.//2009//
/2010/ No change //2010//

Some of the activities conducted during the year:
1. Organizing and participating in the annual World TB Day,
2. National Health Month that coincided with World Day (Annually),
3. Breast Feeding Week,
4. World Diabetes Day,

5. World Food Day,
6. World Population Day,
7. Immunization Week.
8. World AIDS Day, and the
9. National Week for the Disabled. The same activities also conducted during the year as our annual activities.
No change.//2007//
/2009/These activities are conducted on an annual basis.//2009//

Laura Health Center is on regular staff receiving salary from the MCH Block Grant. While on a regular weekly basis, one OBGYN or CNM, and one RH Nurse join the health assistant and full RH service is being provided, such as Prenatal clinic, women/male health clinic, FP and other RH services.
/2010/ No change. //2010//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	595.3	239.3	181.1	123.2	83.9
Numerator	527	213	136	94	65
Denominator	8853	8900	7508	7632	7748
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
/2009/ The data system has been improved over the past, but still needs to be improved to capture better date regarding this HSC. There is a development of new information system should be imprlemented this year, therefore, data base on age break down on this HSI will be reported in the next reporting cycle.
//2009//The data system is still in the process of development and hopefully by the end of this year should be able to implemented the new system.
/2010/ The New Information System is still under development with 20% of Majuro Hospital data has been input into the system. Public Health where Reproductive Health (MCH/CSHCN/Family Planning data is included, is still not yet done. Hopefully by the first part of 2010, they system will be fully impletented, so that better data will be available. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1584	1650	1578	1591	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Not applicable to the RMI since RMI does not have Medicaid.

Notes - 2007
Not applicable to the RMI since RMI does not have Medicaid.

Notes - 2006
Not applicable to the RMI since we do not have Medicaid.

Narrative:
This is not applicable to the RMI since we do not have Medicaid. Under of the Compact of Free Association with the U.S.A., RMI is not eligible for Medicaid.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1584	1650	1578	1591	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
RMI doen't have SCHIP.

Notes - 2007
RMI don't have SCHIP.

Notes - 2006
RMI don't have SCHIP.

Narrative:
Not applicable to the RMI since RMI does not have SCHIP. Data shown here is being collected throughout the year.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	17.7	18.4	94.6	75.1	70.5
Numerator	280	302	1555	1188	1076
Denominator	1584	1643	1644	1581	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Beginning with the 2007 annual report, the Pacific Basin Jurisdictions may have changed to the World Health Organization (WHO) standard rather than the Kotelchuck Index to report indicator data for HSCI04. The WHO standard recommends as essential that pregnant women make four prenatal care visits.

Notes - 2006

This is estimated, since the it is based only on Majuro Clinic log book and prenatal entry data.

Narrative:

/2010/ The new data system that is in the process of developing and hope to be completed in the first part of 2010, this would improve the our data collection and reporting. This data system will be used by the state Health Service.

Due to data under reporting, most of the data reported is being from Majuro. It is believe that the percentage of prenatal entry into the 1st trimestion for Majuro MCH clinics is higher than what is appeared here. The RMI has not implemented the WHO standards, but it is planned to implement with the new 5 years Assessment with a base line.

The Maternal and Child Health Program continues increase the number of mothers entry into prenatal care in the first trimester, one expanded prenatal clinic in addition to the base clinic has been established at Laura Health Center located in Majuro. The new site gives more access to not only the mothers, butr also all MCH population who are unable come to the main clinic due to cost of transportation costs.

RMI will still use Kotelchuck Index.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.0	0.0	0.0	0.0	38.1
Numerator	0	0	0	0	11374
Denominator	22281	23906	29800	29900	29816
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
RMI don't have Medicaid Program. After we submitted the grant, EPPSO submitted single age population for 2008. So for the year 2008, we are going to use this data.

The numerator is based on the first visit of children in Outpatient Services in Majuro Hospital and Ebeye Hospital.

For the Health Centers in the Outer Islands, the data are submitted monthly. We didn't include it at this time because the data for Majuro and Ebeye are computed yearly. We will work on our data uniform collection on the next year assessment.

Notes - 2007
RMI don't have Medicaid Program. Number of children age 1 to 21 years old is estimated based on population for ages 0-24 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

Notes - 2006
Not applicable to the RMI since RMI does not have Medicaid Program.

Narrative:
RMI does not have Medicaid Program/Not applicable to the RMI.
/2010/ Although RMI don't have Medicaid program, children in the RMI received services that is covered under the RMI Medical Insurance. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	7619	7619	7100	7000	6005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Notes - 2007
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Notes - 2006
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 5-9. So for the age 6 to 9 years old, we estimated it based on the 5-9 years old data.

Narrative:
No t applicable to the RMI since RMI is not eligible for EPSDT.
/2010/ RMI don't have EPSDT. There are 6,900 estimated children living in RMI for the year 2008.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1548	1625	25498	25264	25000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 0-19. So for the age 0 to 16 years old, we estimated it based on the 0-19 years old data.

Notes - 2007
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 0-19. So for the age 0 to 16 years old, we estimated it based on the 0-19 years old data.

Notes - 2006
RMI don't have EPSDT. For the denominator, EPPSO (our national population and planning office) don't have the population by single age. We have population data for ages 0-19. So for the age 0 to 16 years old, we estimated it based on the 0-19 years old data.

Narrative:
RMI does not eligibel for SSI ,/Not applicable to the RMI.
/2010/ RMI does not have SSI beneficiaries, 2008, 25000 children received some sort of rehabilitative services under RMI Medical Insurance. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**		
Comparison of health			**MEDICAID**	**NON-**	**ALL**

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				**MEDICAID**	
Percent of low birth weight (< 2,500 grams)	2008	other	0	13.8	13.8

Notes - 2010
RMI don't have MEDICAID. Data source is from registered birth certificates.

Narrative:
Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.
/2010/ Data from the Ministry's Vital Statistics Office has shown that in 2008, about 13.8% of total births were LBW (<2,000 grams). //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	0	47	47

Notes - 2010
RMI don't have MEDICAID. Data source is from registered death certificates.

Narrative:
Not applicable to the RMI since is not eligible for medicaid care under the Compact of Free Association with the U.S.
/2010/ Data has shown that in 2008, the number of infant death has decreased by 4. In 2007, the number of infant death was 51/1000 live births, while in 2008 it came down to 47/1,000 live birth. Improvement has shown, but still needs to improve. Counseling during pregnancy and at postpatum has contributed to this improvement. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in	2008	other	0	70.5	70.5

the first trimester					

Notes - 2010
RMI don't have MEDICAID. Data source came from the Reproductive Health Clinics.

Narrative:
Not applicable to the RMI since RMI does not eligible under the Compact of Freely Association with the U.S.
/2010/ Although RMI does not have Medicaid, we provide prenatal services in the Reproductive Health Clinics in the hospitals and health centers. In 2008, the number of prenatal visits into the 1st trimester is slightly lower than 2007. It has do with the decreased in number of births in 2008. Over the years, Marshallese people have been migrating out the country to seek better education and work. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	0	70.5	70.5

Notes - 2010
RMI don't have MEDICAID. Data source came from Reproductive Health Clincis.

Narrative:
Not applicable to the RMI since RMI does not have medicaid care therefore data between medicaid and non-medicaid can not be compared.
/2010/ Because MEDICAID in not appicable to RMI, our data reflects the percentage of non-medicaid women with adequate prenatal care provided in the hospitals and health centers. For the next year, we are going to be more keen in encouraging the pregnant women to attend our prenatal clinics. We will emphasize the advantages of prenatal for delivering a healthy baby. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP**	**YEAR**	**PERCENT OF POVERTY LEVEL**

programs for infants (0 to 1), children, Medicaid and pregnant women.		SCHIP
Infants (0 to 1)	2008	150

Notes - 2010
RMI don't have MEDICAID. Since this page can't accept 0 value, I entered 100.

Narrative:
Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.
/2010/ Based on the Federal Guideline on poverty level, most of our popualtion falls under the guideline. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 10) (Age range 11 to 18) (Age range 19 to 22)	2008	 100 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 4) (Age range 5 to 10) (Age range 11 to 18)	2008	 150 150 150

Notes - 2010
RMI don't have MEDICAID. Since this page can't accept 0 value, I entered 100.

Narrative:
Not dapplicable to the RMI since RMI does not eligible under the Compact of Free Association with the U.S.
/2010/ Based on Federal Guideline on poverty level, most the our population falls under this guideline. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	150

Notes - 2010
RMI don't have MEDICAID. Since this page can't accept 0 value, I entered 100.

Narrative:
Not applicable to the RMI since is not eligible under the Compact of Free Association with the U.S.
/2010/ Eventhough, RMI does not eligible for Medicaid and SCHIP programs, Maternal and Child Health Program servied 1526 pregnant women in 2008. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	2	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
/2010/ The MCH program coordinates with other programs within the Ministry and other governmantal agencies to have access to policy and program relevant information.

Annual Data Linkages:
1. MCH Program can obtain data from the Health Planning and Statistics Office which

handles the birth and death certification. Upon request, data is available.
2. With the newborn screening grant that was approved this year (2009), we will work on the revision of our birth certificate to accomodate the newborn screening test/result. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes

Notes - 2010

Narrative:
Steps has been taken to have access to information whose dealing with the youth organizations and the youth programs throughout the Republic. The program staff in collaboration with the Internal Affairs and Youth to Youth in Health and Ministry of Education formed as a "Mobile" team and do outreach activities as well providing health education regarding youth behavior, including using tabocco product.
/2010/ The MCH Program continues to expand its services to reachout adolescent who are in schools. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2009/ Based on health data collected by the MCH Program, the RMI MCH/CSHCN has selected the same priority needs in which some of them has been selected from the last year's needs. These priority needs have been selected to improved the health status of mothers, infants, children, youths in the RMI in all four of the services described in the pyramid. //2009//The RMI has selected to continue with last year's priority needs.
/2010/ No change. //2010//

B. State Priorities

These are all indicators that the MCH program and services must challenge each year.

Direct Health Care Services:

B. State Priorities

//2009// Base on health data collected by the MCH Program the RMI MCH/CSHCN has selected the same priority needs mostly as last year's needs but with some additional areas of needs. These priority needs have been selected to improved the health status of mothers, infants, children, and youths in the RMI in all four of the services described in the pyramid. //2009//RMI has selected to continue with the same priority needs as last year's.
/2010/ No change. //2010//

1. To reduce infant mortality rates.
2. To reduce the rates of teenager pregnancy.
3. To Increase the rates of prenatal visits during the first half of pregnancy.
4. To reduce neonatal mortality and morbidity.
5. To increase access to preventive services for women who are at risk for cancer.
essential data and statistics on how the Ministry can improve programs and services.
6. To reduce the rates of sexually transmitted diseases among women of child-bearing age.
coordination of services between agencies for CSHCN.
7. To strengthen the Health Information System to provide essential data to strengthen health care services focusing on preventive services.
8. To improve accessibility to the MCH/CSHCN services for children 0-21 and their families.
9. To improve preventive services for school children in dental care, immunization, and nutrition.
10. To strengthen screening programs on hearing to infants and young children.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	0	0	0	0	10
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0

Denominator	1512	1650	1578	1591	1526
Data Source					Medical Record.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15	20	25	30	35

Notes - 2008
We don't have a newborn screening in place this year.

Notes - 2007
RMI don't have newborn screening in placed.

Notes - 2006
RMI don't have newborn screening in placed.

a. Last Year's Accomplishments
PM#1 is not applicable in the RMI since there is no newborn screening program yet. But in some cases, new borns who are in serious condition are requested to be tested and blood samples are shipped to off island diagnostic services. It is not very common (around once or twice monthly) and for those very sick newborns.

RMI don't have mandated newborn screening yet. Hopefully, newborn screening program will be ready for implementation in 2010. In 2008, there are 1526 registered births and services like assessment after birth, pospartum and follow up after discharged from the hospitals and health centers are provided.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. This is not applicable to the RMI since RMI does not have mandated newborn screening program yet.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Although, there is no newborn screening program in place yet. A routine general screening is an on-going activity for newborns. Newborns are examined by the pediatrician at the time of delivery. Examination includes physical exam. If newborn is under the category of CSHCN, the pediatricians endorse the newborns to CSHCN coordinator. For very sick newborns that need

blood testing, blood samples are shipped to off island diagnostic centers like in Honolulu for testing. For 2008, there are 1526 registered live births.

c. Plan for the Coming Year
Plan for FY 2010
1. To develop a newborn screening program for the Ministry. We are waiting for the result of the newborn screening grant that we submitted this year.
2. With the newborn screening program, we need to update our birth certificate to accommodate the screening data.
3. To continue with the routine new born exam until an official newborn screening program is in place.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9	9	9	9	100
Annual Indicator	100.0	100.0	90.8	100.0	100.0
Numerator	361	395	395	445	461
Denominator	361	395	435	445	461
Data Source					MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Program short Survery.

Notes - 2007
This is being by evaluating with short survey asking parents or caretaker is they are satistied at what level.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The MCH/CSHCN program has met this National Performance Measure by conducting 10 more additional follow-up visits with parents and families in collaboration with the public health teams

and zone nurses. The Core Committee has developed an ongoing list of specific questions for both clients and families that will help the providers plan the care that is needed for their children with special health care needs. MCH/CSHCN program continues similar activities during trainings, community outreach follow-up with clients, and community awareness on MCH programs and activities. The MCH program continues to focus more on the community as a whole. In 2008, 461 children and families are currently receiving services from MCH children with special health care service.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of screening element/mechanism to identify child with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can receive the care needed.	X			
3. On-site training of the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zonal, outer atolls trips and screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. The RMI MCH/CSHCN program continues to provide medical health care services to all the children and families
who have been identified and confirmed to have disabilities.
2. Continue to screen and refer clients to the pediatricians or the physicians on call. This is an ongoing collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Screening is done after delivery and during well baby clinics and community outreach activites including outer island visits.
3. Strengthens the coordination and collaboration between the Ministry of Health and Ministry of Education by joint effort to provide more access to services and as well as parents/families participate more in decision making for their children. Evaluation and monitoring for justification is being done by asking questions to find out if their needs have been met.

c. Plan for the Coming Year

1. The RMI MCH/CSHCN program will continue to provide medical health care services to all the children and families who have been identified and confirmed to have disabilities.
2. Continue to screen and refer clients to the pediatricians or the physicians on call. This is an ongoing collaboration with medical staff in the two urban centers who provide services for all infants and children in the Marshall Islands. Screening is done after delivery and during well baby clinics and community outreach activites including outer island visits.
3. Strengthens the coordination and collaboration between the Ministry of Health and Ministry of Education by joint effort to provide more access to services and as well as parents/families

participate more in decision making for their children. Evaluation and monitoring for justification is being done by asking questions to find out if their needs have been met.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	361	395	435	445	461
Denominator	361	395	435	445	461
Data Source					MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Results from program survey.

Notes - 2007
Result from Program survey with questions.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
This performance maintains its level at 100%. The Ministry of Health being the "state" health agency provides medical health care services both curative and preventive to all residents through the state hospitals in Majuro and Ebeye and health centers in Outer Islands. Infant and children who have been identified were referred to the pediatricians or the physician on call who became their primary physician for the referred cases. RMI continues to maintain the NPM at 100% in involving all CSHCN and families in their daily medical care at homes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to do home base care/visits to evaluate and monitoring of clients.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. The MCH/CSHCN program continues to collaborate with medical staff at the hospitals in providing health services to all infants and children.
2. The MCH/CSHCN program continues to provide services for these children and families on a home base care.
3. The MCH/CSHCN program continues to screen and identify infants and children for any disable conditions and refer to the services that they need.

c. Plan for the Coming Year

1. The Ministry of Health being the "state" health agency will continue to provide medical health care services both curative and preventive to all residents through the state hospitals in Majuro and Ebeye and health centers in Outer Islands.
2. The MCH/CSHCN will continue to collaborate with the medical staff in the urban centers and rural health centers in providing health care services to all infants and children.
3. The MCH/CSHCN will continue to maintain its 100% status in providing comprehensive medical home care to the CSHCN.
4. RMI will continue to provide the services for the CSHCN and families at home during outreach clinics and site visits to the outer islands.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	86	90	95	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	361	395	435	445	461
Denominator	361	395	435	445	461
Data Source					MCH Program
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Results from program short survery.

Notes - 2007
Results from program suvery/evaluation.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
This Performance Measure remains the same as last year. The Republic of the Marshall Islands health insurance policy covers all Marshallese citizens. Medical services are provided to all residents from the Ministry of Health, which includes the two hospitals in the urban centers and the health centers in the outer atolls (the MCH population is included). This remains at 100% coverage with the Marshall Islands health insurance policy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to identify those children who are at risk to provide the service free of charge.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RMI MCH/CSHCN provides medical health care services. The health insurance policy covers Marshallese citizens and non-Marshallese who that the policy. The RMI MCH/CSHCN continues to focus on efforts to screen all children to identify CSHCN and refer to CSHCN program. CSHCN program provides service to these clients free of charge. This is an on-going policy for the RMI that includes the MCH/CSHCN population.

c. Plan for the Coming Year

Planned Activities 2010: The Ministry will continue to focus its efforts to screen all children in order to identify the children with special health care needs and refer them to the CSHCN program. The MCH/CSHCN program will continue to coordinate and collaborate with the hospitals, health centers, public health outreach teams, zone nurses, and other agencies providing health care services for these children and families to improve delivery of health care for these children and their families. RMI will continue to maintain the service at its present level 100% coverage.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	85	90	95	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	361	395	435	445	461
Denominator	361	395	435	445	461
Data Source					MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
CSHCN survery.

Notes - 2007
CSHCN survery.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Annual Performance Objective: 100%
The RMI MCH/CSHCN program continues to provide services. MCH/CSHCN receives referral cases and/or reports from the families of CSHCN and the community through the health workers/health assistants assigned to that community. The MCH/CSHCN continues to provide services such as nutrition counseling, oral hygiene, etc.) for the CSHCN and families in the community. CSHCN service is available on the community level where clients and families are referred.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and refer of clients t the pediatricians or the physician on call.		X		
2. Collaborate with medical staff in the hospitals who provide health services for all infants and children.		X		
3. Identify and refer of clients to the pediatricians or doctor on call.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The RMI don't have actual community-based system yet. However, the families report to the health workers/health assistant who is assigned to that community. The CSHCN's families have access to information and services in their community which are referred to the MCH/CSHCN program. Better communication has been established between the MCH office and the clients. A direct telephone line has been established to the clients and their families. This gives them better, easy, and free access to the program. In addition, the CSHCN program office can be reached through email and fax.

MOH continues to utilized the Health Centers for the outer islands and the two main hospital in Majuro & Ebeye to make the services availlable at the community base level. Other information can be obtained from any health centers and in the hospitals throughout the RMI.

c. Plan for the Coming Year

Annual planned activities 2010:
1. The RMI MCH/CSHCN program will continue to provide services and receive referral cases/reports from the families of CSHCN or the community through the health workers/health assistants assigned in that community. 2. The MCH/CSHCN will continue to provide services , such as nutrition counseling, oral hygiene, etc.) for those CSHCN and families in the community. 3. CSHCN service is available on the community base where clients and families will then refer to and also get the refer to the MCH/CSHCN program at the MOH.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	9	9	91	91	93
Annual Indicator	77.6	83.5	94.3	54.2	60.7
Numerator	280	330	410	241	280
Denominator	361	395	435	445	461
Data Source					MCH program survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	98	98	98	98

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Accomplishment 2008: The RMI MCH/CSHCN program collaborated with the Ministry of Education in making transition of children with special health care needs. The MCH/CSHCN program referred 6 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools. There's an ongoing collaboration and coordination between CSHCN Coordinator and the Ministry of Education. The CSHCN/Education Council has a very strong support to the service. In 2008, 3 students graduated from high schools. This is the 1st time that children with disabilities graduated from high school. Now they are ready to continue on to college or further their education somewhere outside the RMI.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate with Ministry of Education to prepare these youth for further education or even get a job.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Accomplishment 2008:
1. The RMI MCH/CSHCN program provided its services to the CHSCN thru collaboration with the Ministry of Education in planning and providing education.
2. The MCH/CSHCN program referred 6 children to the Special Education program in the Ministry of Education so that they could attend schools, both primary and secondary schools.
3. We had meetings on quarterly regular basis to bring up any issues regarding the transition period to prepare these children.

c. Plan for the Coming Year
Planned Activities 2010:
1. The MCH/CSHCN program will continue to collaborate and coordinate with the Ministry of Education.
2. Maintain that contact with Ministry of Education, parents, and community members at the present level.
3. The program will continue to meet with the RMI National Council for Children with Special Health Care Needs on a quarterly basis in which parents are included in the committee. One of the objectives of the meetings is to discuss the plan of care for their children.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	60	65	73	95
Annual Indicator	49.5	61.0	72.0	82.0	88.1
Numerator	1435	925	1152	1649	1728
Denominator	2899	1516	1600	2010	1961
Data Source					Immunization Logbook
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	95	95	95	95

a. Last Year's Accomplishments
Performance objective: 95%
For FY 2007, the immunization coverage for 2 years improved from 72% in FY 2006 to 82%. Data has shown that the immunization for 2 year old has been improving compare to the previous years. The immunization staff, including public health staff has taken steps to further provide the immunization coverage for children at age 2. More home visits with the zone nurses, including the outer islands trips.

In 2008, the immunization coverage has improved. RMI accomplished 88.1% immunization for

children 19-35 months, but still needs to improve. Immunization coverage for 2007 was 82% while in 2008 has increased to 88.1%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to do outreach activities to be able to do follow-up and up-to-date of immunization records.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. The zone nurses continue to do outreach in the communities, visits the outer islands to provide immunization for the children who reside on these islands/atolls,
2. Daily immunization at public health clinics both in Majuro and Ebeye,Kwajalein Atoll.
3. Public awareness on the importance of having their children complete their immunization series by age 2 years old, for example using mass media, radio spots, local newspaper, etc.

c. Plan for the Coming Year

Planned Activities 2010:

1. The RMI will continue to intensify its immunization coverage rate during community outreach activities (zone activities), outer islands trips/visits, and the public health clinics. These nurses will continue to work closely with the health assistants in the outer islands/atolls, including the public health teams.
2. Continue to increase the immunization rate by reaching out into the community on a regular basis, and continue to do public awareness using mass media.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	125	100	100	100	95
Annual Indicator	167.3	47.4	33.8	44.9	39.5
Numerator	253	93	71	92	79
Denominator	1512	1961	2100	2050	2000

Data Source					Health Planning.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	46	46

Notes - 2008
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,083.

Notes - 2007
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,189.

Notes - 2006
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,304.

a. Last Year's Accomplishments
Annual Performance Objective:
The age group in the particular category included teenagers 15 through 17. For FY'08, there were total number of 79 teenage pregnancy. Data for this performance measure has shown that teenage pregnancy is slightly decreasing. Based on the Healthy People 2010, ou data is still high. There is a need to improve the services.

In comparison, for FY 2007, the total number of teen pregnancy was 92 while in FY 2008 it was 79. More effort was done in reaching the youth in the community. In the high schools, there are 10 more additional fairs have been done on teen pregnancy.

Collaboration and partnership with the Youth to Youth in Health has a strong part in making this difference. The family planning at the Youth to Youth in Health building has been re-activated and now it is operating on regular basis and staff by a regular family planning GN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue its effort to decrease the rate of teen pregnancy in		X		

the RMI by improving health education and promotion activities for youths.				
2. Conduct more training in the community, including traditional leaders on issues regarding health promotion and family planning.		X		
3. Coordinate and collaborate with the Youth to Youth In Health to continue its effort in strengthen the Reproductive Health Clinic located at the Youth to Youth in Health Base.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Decrease in the rate of teenager pregnancies is a challenge for RMI.
1. Improve and promote health education activities for youths and Laura Health Center (LHC).
2. We eliminated the barriers that inhibit accessibility to family planning services for youths by expanding services into the community and to the public.
3. Conduct training for the community leaders on the issues presented in the National Population Policies.
4. The Youth to Youth in Health provides family planning counseling at the Youth clinics in Majuro and Ebeye. The Reproductive Health/Family Planning clinics continue at the Youth to Youth in Health site on a regular basis
5. More youth site visits to the outer atolls in collaboration with the Community were done.
6. One family planning nurse (A.S. Level) is based at this clinic site so that the family planning services will be available at all regular times.
7. Clinic hours in YTYIH has been expanded from the 5:00pm to 7:00pm. This gives more access for the teens in schools or staying far from the clinics.

c. Plan for the Coming Year

Planned Activities 2010:
1. The RMI will continue to focus its effort to decrease the rate of teenager pregnancies in the coming year by improving health education and promotion activities for youths and conduct more training for community leaders on the issues presented in the National Population Policies.
2. More activities on health promotion and family planning targeting to meet the needs of youths in the RMI.
3. The Youth to Youth in Health will continue its effort to add one more youth clinics in the rural areas and urban center(Ebeye) in collaboration with the Community.
3. Continue to expand the clinics hours at the Youth to Youth in Health
4. Increase the number of clinic days for Laura Health Care Center to provide more access for the teen who live far from the main health services.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	70	80	80	85	90
Annual Indicator	87.1	77.9	82.6	64.2	85.3
Numerator	1842	1643	1743	1355	1800
Denominator	2115	2110	2110	2110	2110
Data Source					MOH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	85	85	85

a. Last Year's Accomplishments

Annual Performance Objective: 80% of the proportion of 8-9

Accomplishment: It is slightly lower the denominator for the performance since we were not able the to do out reach to the outer islands for more than seven months since the plans (Air Line of the Marshall Islands has been having mechanical problems. During the FY 2007, the program was able to provide services mostly on Majuro. In FY 2007, the Number of school children examined for dental was 1365, and 1355 teeth sealed.

In 2008, we are still running into our airline problems that our regular schedules for the outer is almost impossible. During this period, dental health was able to accomplished to total of 3,179 schools children grade 1, 2, 6 & 7 that the improvement almost three time improved. Dental staff has taken steps to do more outreach to the schools, and serve mainly the grades stated here.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Outreach to provide health education to the students who are the third grade. Provide education for parents who attend clinics on issues concerning oral health.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

As part of the school sealant program, staff provide dental education for the elementary schools that they visits. Oral Health services is being also provided for the schools in the outer islands/atolls during the outer islands visits. Outreach activities continue on a regular basis for the schools. and into the community. Continues with outer islands trips using field trip ship or the plane if available. Dental service serve maimly, grades 1, 2, 6, & 7 in 2008, so the teams visited more schools to provide sealant to the students.

c. Plan for the Coming Year
Planned Activities 2010: Increase health education of oral health in the schools by using posters, educational materials on oral health. Implementation of school sealant program in the outer islands. Continue to expand oral health services for the by addition 10 more Elementary School children, grades 1, 2, 6, & 7.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9	9	9	9	8
Annual Indicator	15.3	13.6	4.7	18.5	9.2
Numerator	5	3	1	4	2
Denominator	32654	22128	21361	21597	21839
Data Source					Medical Record.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9	9	9	9	9

a. Last Year's Accomplishments
Annual Performance Objective: 9 per 100,000
Accomplishment: There were 2 documented deaths to children 0 -14 due to motor vehicle crashes in FY 2008. Data shows that the objective was met. However, it still remains as one of our concerns because of young children dying due to accident. There are more vehicles and limited space for playing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand the outreach health education for parents, the public on importance of safety (example, school cross-walks/car seat belt, etc.).			X	
2. Better coordination with public safety and providers who provide safety in the schools or any public places.			X	
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Our health education and promotion activities continue to address this issue by public awareness on proper road and pedestrian safety. There is school law in place that vehicles must stop when crossing the roads. Though some of the drivers don't follow the law. It is also mandated to use seat belt at all times. The program continues to coordinate with other progams within the MOH, Police, and the public.

c. Plan for the Coming Year
Planned Activities 2010:
1. The MOH will continue to provide public awareness through health education and promotion. Our health education and promotion activities will continue to address this issue to ensure that lesser deaths caused by motor vehicle crashes occur.
2. Continues to coordinate with the Ministry of Public Safety for the safety of children using the cross-walks.
3. Inforced the seat belt law.
4. Inforced the speed limit.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			70	75	98
Annual Indicator		99.5	97.1	91.9	93.1
Numerator		1093	2009	1644	1608
Denominator		1099	2069	1788	1727
Data Source					Nutrition Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98

a. Last Year's Accomplishments
The MCH in collaboration with the Health Education and Promotion, Core Community and the Breast Feeding Policy Committee continue to develop and distribute educational materials, provide nutrition counseling during prenatal clinics, conduct presentations during prenatal clinics and the maternity ward with mothers, and continue health promotion outreach in the communities and through mass media. Staff in the Health Education continue to provide information on breast feeding issues on a weekly regular radio program. In FY 2008 the percentage of women who

breast-feed their babies up to 6 months which is at 93.1% compare to 2007 which was 91.9% and data has shows improvement, but still needs to improve.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the outreach health education for the reproductive age in the community, including parents, youth groups, woman's organizations, etc.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

1. Conitues to provide health education regarding the importance of breast feeding in the first 6 months of life. 2. Continues to promote breast feeding advantages using radio spots, newspaper, outreach, including outer islands activities.
3. Enforce breast feeding policy/baby friendly hospital.
4. Do more talks during prenatal clinics on advandages and disadvangatges of breastfeeding vs bottlefeeding.

c. Plan for the Coming Year

Planned Activities 2010:
1. The MCH will continue to collaborate with the Health Education and Promotion Unit, Core Community and the Breast Feeding Policy Committee in disseminaing of educational materials, and will continue to provide nutrition or healthy diet in breastfeeding mothers counseling during prenatal clinics.
2. Continue to conduct presentation during prenatal clinics and at the maternity ward with mothers.
3. The MCH program will continue breastfeeding promotion during outreach in the communities and through mass media.
4. Breast Feeding policy will be reminded and discuss with members of the Community Leaders Committee during community outreach and during training in the the urban centers.
5. Staff in the Health Education will continue to discuss breast feeding on the a weekly health education radio program.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	0	20	25	30	35
Annual Indicator	11.4	16.1	0.0	0.0	0.0
Numerator	172	261	0	0	0
Denominator	1512	1625	1579	1591	1526
Data Source					Medical Record.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	40	45	50	55

Notes - 2008
RMI don't have newborn screening test.

Notes - 2007
RMI don't have newborn screening test.

Notes - 2006
RMI don't have newborn screening test.

a. Last Year's Accomplishments
This performance is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals. However, it is estimated that 19.2% of the new-born are screened for some hearing (routine) problem.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate and coordinate more with the doctors in the delivery units and also those who attend to that delivery at the point in time.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This performance is not applicable to the RMI since screening for hearing impairment is not conducted in the hospitals. Continue to do complete examination before discharge from the hospitals.

c. Plan for the Coming Year
This National Performance Measure is not applicable to the RMI. The newborns are not screened for hearing impairment before hospital discharge. Development of an hearing test screening to be implemented no later than the end of FY 2010.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0	0	0	100	100
Annual Indicator	0.0	100.0	2.0	2.0	2.0
Numerator	0	22128	500	500	500
Denominator	32654	22128	25100	25050	25000
Data Source					Health Planning.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2	2	2	2	2

Notes - 2008
Number of children whose age is less than 18 years old is estimated based on population for ages 0-19 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

Notes - 2007
Number of children whose age is less than 18 years old is estimated based on population for ages 0-19 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

Notes - 2006
Number of children whose age is less than 18 years old is estimated based on population for ages 0-19 years old. EPPSO, our planning and statistics office, can't give us specific data per age.

a. Last Year's Accomplishments
Accomplishment: The RMI health insurance policy covers all Marshallese. Medical services are provided to all residents from the Ministry, which includes the two hospitals in the urban centers and the health centers in the outer atolls.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to identify these children to bring them into the	X			

program.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continues and maintains the RMI policy that covers the whole RMI population.

Response: RMI health insurance policy covers all Marshall Insurance

c. Plan for the Coming Year
Planned Activities 2010: The Ministry of Health will maintain the policy that covers medical insurance for the whole RMI population.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			0	10	15
Annual Indicator		0.0	4.2	0.0	0.0
Numerator		0	250	0	0
Denominator		5993	5993	5993	5993
Data Source					Health Planning.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0	0	0	0	0

Notes - 2008
RMI don't have WIC services.

Notes - 2007
RMI don't have WIC services.

a. Last Year's Accomplishments
This is not applicable to the RMI since there is not WIC Program. However, it is estimated that 4.2% is being receiving some sort services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate on regular basis with those service providers that provide some sort of services related to this NPM.	X		X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the WIC Program. However, care service continues to provide assistance for the clients as well more collaboration between the MCH and community in partnership.

c. Plan for the Coming Year
This Performance Measure is not applicable to the RMI since the RMI is not eligible for the Medicaid Program. Continue with the present activities.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				100	2
Annual Indicator			2.5	2.5	2.6
Numerator			40	40	40
Denominator			1578	1591	1526
Data Source					Medical Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2	2	2	2	2

a. Last Year's Accomplishments
In 2008, smoking for pregnant women during the last three of pregnancy in very low, which is less than 3% the total pregnant women. This is good sign for good health during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuing with the current identification of pregnant women who smoke during pregnancy.			X	
2. Provide counseling during prenatal clinics on the dangers of smoking in pregnancy.	X			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Counseling on smoking during pregnancy is being provided during prenatal 1st visit for all pregnant women who come into 1st prenatal booking. Information on smoking in pregnancy is also taught during outreach activities/health fairs in the community. as well as providing educational materials to the clients, and program during outreach clinics.

c. Plan for the Coming Year
Planed for activities 2010: To continue providing the importance information on smoking during pregnancy for the women using radio spots, local newspaper, prenatal clinic and during outreach clinics.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15	9	9	8	200
Annual Indicator	133.3	46.8	29.3	15.2	31.7
Numerator	10	3	2	1	2
Denominator	7501	6409	6837	6568	6319
Data Source					Health Planning.

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					Yes
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	20	20	20

a. Last Year's Accomplishments

Accomplishment:

In 2008, there were 2 completed suicides in this age group Data has shown that there is an increased by 1 in number of suicide, and increasing of participation in alcohol/drug treatment program. Health education and promotion campaigns on mental health and suicide prevention have been expanded to the schools and community groups such as the churches, and youth groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide outreach activities into the schools, youth groups, including parents, church groups, and community.	X		X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Counseling is being provided at the Human Services & Mental Health clinics its participants to the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides. Health Education and the program on Alcohol and Substance Abuse Prevention conduct training with youths, community groups. Health Education is being provided through radio program like interview on alcohol, substance abuse and suicides. Close monitoring and evaluation on the rate of suicides in each community through the year in order to meet the needs of each community.

c. Plan for the Coming Year

Planned Activities 2010:

1. The MCH program will place its effort in collaborating with the Mental Health and Human Services to follow-up with participants of the National Suicide Prevention training to conduct needs assessments on activities pertaining to suicides.
2. The Health Education and the program on Alcohol and Substance will collaborate to conduct more trainings with youth groups, community groups, parents, church groups, and the schools.
3. More educational materials will be developed and the media will be utilized more in radio spots, radio programs and interviews on alcohol, substance abuse and suicides prevention.

4. Close monitoring and evaluation on the rate of suicides in each community will be expanded throughout the year in order to meet the needs of each community.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0	0	0	0	1
Annual Indicator	0.9	0.6	0.0	0.0	0.0
Numerator	13	10	0	0	0
Denominator	1512	1650	14	12	18
Data Source					Health Planning.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

a. Last Year's Accomplishments

High risk deliveries are referred to the two main centers, Majuro and Ebeye in Kwajalein Atoll. In two main hospitals, all care are being provided, otherwise, if a newborn is in bad condition, then he/she is referred out of the Country for further medical care. For 2008, there was 5 documented case of very low birth weight infants delivered at either Majuro Hospital or Ebeye Hospital due to high risk pregnancy. However, any high risk identified are being referred to the urban the urban centers of Majuro Hospital or Ebeye Hospital.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Early identification of risk pregnancies and refer for further medical evaluation and close monitoring be the doctors.	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Early identification of risk factor in early pregnancy and refer to either one the two main hospitals for close evaluation and monitoring. Early screening in the 1st prenatal booking. Risk assessment based on high risk scoring and referral to OB-GYNs.

c. Plan for the Coming Year
Continue with the present activities. Early booking for early identification of any high risk conditions and refer.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	62	45	50	55	80
Annual Indicator	21.5	18.7	98.5	79.9	70.5
Numerator	325	309	1555	1272	1076
Denominator	1512	1650	1578	1591	1526
Data Source					Health Planning.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	80	85	90	95

a. Last Year's Accomplishments
The data has shown that prenatal 1st visit during the first three months of pregancy is improved over the years. In 2008 70.5% entered into prenatal care for the first time in the first three months of pregnancy, compare to 2005 which was only 18.7%. The Reproductive Health staff, including MCH/FP nurses have been taken steps to reach out into the community, including the outer islands trips to expand the delivery of services into the community.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide more public awareness through increasing outreach fairs into the community, collaborate and partner with the youth groups, parents, community, and the public at large.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Outer Islands trips on a quarterly basis. Outreach into the community, and collaboration between the RH staff and public health, and also partnership with the private sectors, including woman's organizations and the youth groups in the community. Provides more access to prenatal care by conducting MCH services twice a week on a regular basis at the Laura Health Center (RH extended clinic).

c. Plan for the Coming Year
To increase by 5% from present in 2010. Continue the present activities.

D. State Performance Measures

State Performance Measure 1: *Percentage of mothers who receive nutrition and family planning counseling during prenatal care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			100	100	100
Annual Indicator	100.0	92.1	98.5	79.9	70.5
Numerator	1584	1520	1555	1272	1076
Denominator	1584	1650	1578	1591	1526
Data Source					RH Clinics
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	80	85	90	95

a. Last Year's Accomplishments
Annual Performance Objective: 100% of pregnant women during the first booking/entry into prenatal care.
Accomplishment: In 2008, data has shown that there SPM #1 is improving, but there is still need to improve. All pregnant women who enter into prenatal for the first booking/registration receive counseling on nutrition and family planning. Counseling and registration on nutrition and family planning are also being provided in the follow-up upon delivery and again when the mother comes back for postpartum clinic.

Women also receive services from male, but this is challenge because of they might me related to each other that makes it difficult to seek medical attention from a male.

One expanded MCH clinic site has opened recently at the Laura Health Center, located in Majuro. The purpose of this expanded clinic is to give MCH population reside far from the main Majuro Hospital more access to MCH services, especially prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In-service continuing education in nutrition and family planning for public health nurses , family planning staff for better counseling for the MCH population.			X	
2. Counseling on family planning/nutrition is also being provided during postpartum clinics.	X			
3. Nutrition counseling is being provided for mothers attending prenatal clincs	X			
4. Health educator from health education department provide counseling on nutrition and family planning for women referral.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities: These activities are being carried out as routine part of the prenatal protocol, counseling on nutrition and family planning are provided for all pregnant mothers attending prenatal clinics during first visit which is a part of the interview during booking/registration for entry into prenatal care. It is also provided in the follow-up upon delivery and again during postpartum

Continuing education for nurses is being done through the Ministry of Health's Continuing Education program and is also being done by going off islands for short or long terms trainings.

More access to counseling on nutrition and family planning in pregnancy providing in the main MCH base clinics (Majuro Hospital, Ebeye Hospital, and Outer Islands Health Centers) and Laura Health Center.

c. Plan for the Coming Year

Performance Measure: 75%

Planned Activities: The nurses in the Reproductive Health/Public Health will be up-date in skills through in-service in nutrition and family planning to be able to provide better counseling to all pregnant women who come to the prenatal clinics and the health zones. While it is anticipated that counseling on nutrition and will not be provided to all pregnant women in the outer atolls because of the cultural barriers. Plans are being develop to increase the coverage as much as possible. A protocol has been implemented to ensure that pregnant women are counseled on nutrition and family planning for those referred from the prenatal clinic. Diabetes and hypertension will also be added to the counseling schedule on pregnancy.

Few years ago, the Ministry recruited female and trained them to be health assistants for the outer islands. Education the public continues to provide public awareness about health and the importance to come forward and talk openly about their own health.

One RH nurse has just completed a course on MCH in Japan. She is now sharing what she has learned with other RH staff, including counseling on MCH issues. Continues with the existing program activities, such as outreach activities for both Majuro, Ebeye and the Outer Islands. Continue to provide information to the schools (high schools/school dropouts) on the importance health diet and family planning.

State Performance Measure 2: *The birth rate(per 1,000) for teenagers age 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			20	15	10
Annual Indicator	30.3	47.4	33.8	44.9	39.3
Numerator	253	93	71	92	79
Denominator	8363	1961	2100	2050	2010
Data Source					Health Planning.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	40	38	38	36

Notes - 2008
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,083.

Notes - 2007
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,189.

Notes - 2006
Denominator is estimated based on the 15-19 years old population from Economic Policy, Planning, and Statistics Office (EPPSO). EPPSO don't have single age population. Population for 15-19 years old is 3,304.

a. Last Year's Accomplishments
In 2008, the teenage pregnancy has been slightly decreasing by 9 (total of 83), compare to FY 2007 which was the total of 93. The health, social and economic burdens directly associated with teen pregnancies, has been be aggressively stressed and conveyed to assist in reversing the current status. More than 15 community health fairs have been done for the childbearing women focusing reproductive health, including teen pregnancy and this was also done for more than 9 schools and churches youth to increase their level of understanding on issues concerning teen pregnancy.
More improvement needs to be done. Given the MCH more access to MCH services by opening of one MCH clinic site at the Laura Health Center, increase fo teenagers seeking family planing services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide health education for the teenagers, schools, high school drop-out, and the parent education regarding teen pregnancy.	X			
2. Provide counseling for the teenagers to increase their level of understanding about teen pregnancy.			X	
3. Provide information for youth in the community regarding teen pragnancy.			X	
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Trainings has been established and is an on-going to train and re-train the new Reproductive Health staff, Health Assistants, parents, and other health providers on issues concerning reproductive health, and family planning, including teen pregnancy. Health education is being provided for the public to increase the awareness on issues concerning teen pregnancy through Marshall Islands News Paper, radio announcements, and visiting into the communities.
Provide counseling activities on reproductive health, including, nutrition and family planning, and the improtance of understanding our reproductive health.

c. Plan for the Coming Year

Continues to improve the outreach health education in collaborating with the health education staff, public health staff, and other health care providers in increase public awareness. The reproductive health outreach activities is to be reestablished to reach out for the teenagers who are not in schools. Strengthen the community outreach activities and site visits to the outer islands to reach out for the teen population.

The FP clinic sites both have privacy that service is being provided one-on-one basis. The provide access to the services to the schools, and the public so they have better access to the services than in the past.

Better coordination and collaboration between MCH and other government agencies and develop an MOU between MOH and NOGs, Womens' organizations, Churches and the community.

State Performance Measure 3: *The Percentage of pregnant women who receive prenatal care during the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective				70	73
Annual Indicator		18.7	98.5	79.9	70.5
Numerator		309	1555	1272	1076
Denominator		1650	1578	1591	1526
Data Source					Health Planning.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	80	85	90	95

a. Last Year's Accomplishments

Notes - 2007
Data shown here is based only on Majuro clini2009 This measure was discontinued since it

deplicates cs.

Notes - 2005
Data for 2005 is only for Kwajalein and Outer Islands. There was no data available for Majuro Atoll for this year.

a. Last Year's Accomplishments
During FY'07, the MCH program was able to accomplished 80.4% compare to FY 2006 68.8% of prenatal first visit during the 1st trimester. It has been shown that more pregnant seeking care during the first three months of pregnancy. The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care.

The data has shown that prenatal 1st visit during the first three months of pregancy is improved over the years. In 2008 70.5% entered into prenatal care for the first time in the first three months of pregnancy, compare to 2005 which was only 18.7%. The Reproductive Health staff, including MCH/FP nurses have been taken steps to reach out into the community, including the outer islands trips to expand the delivery of services into the community.

2009 This measure was discontinued since it deplicates a National Performance Measure.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. This SP will be reported with the National preformance Measure #18	X			
2. SPM was discontinued since it duplicate a NPM.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care. Clinics hours continue as well as other prenatal routines activities. Also, the reproductive health clinics have been expanded to include two additional clinics with one of them extended clinic hours from 5:00pm regular normal. These two expanded clinic sites are, one at the Laura Health Center(LHC), and the second one is located at the Youth to Youth In Health Clinic. These new clinics sites is give the MCH population more access to reproductive health services. The LHC clinic provide all MCH services, including prenatal, postnatal, women's heatlh, and family planning, the clinic at the Youth to Youth in Health provides RH services, including youth's health up to 25 years of age. We've seen more youth seeking services from this clinic.

2009: This SPM discontinued since it duplicats a NPM.

c. Plan for the Coming Year
The RH staff in collaboration with the Public Health staff visit the communities, including outer islands site visits and part of the service being provided is public health education on why early prenatal care important. This is being done to improve the public awareness regarding the important of prenatal care. Clinics hours continue as well as other prenatal routines activities. Also, the reproductive health clinics have been expanded to include two additional clinics with one of them extended clinic hours from 5:00pm regular normal.

2009: This SPM was discontinuws since it duplicates a NPM. Note: A new SPM will be included in the next grant cycle.

State Performance Measure 4: *The percentage of high risk pregnant women who are identified and are referred to special prenatal services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			100	95	90
Annual Indicator	25.4	12.8	9.1	15.4	13.1
Numerator	298	145	144	245	200
Denominator	1175	1136	1578	1591	1526
Data Source					Health Planning.
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	80	80	80	75

Notes - 2007
There is different notice in data here since it is focused only on Majuro clinics.

a. Last Year's Accomplishments
Accomplishment: During the FY 2008, 200 high risk pregnant women seeking early prenatal care are identified early and placed in the high risk special care. Improvement is still needed that the number of prenatal clinics increased from once a week to five full days a week. The expansion of the RH/MCH clinic sits give better access to the service for the MCH population who resides far from the center and unable affort cost of transportation to come to the main hospitals.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screening of high risk pregnant women during the 1st trimester.	X			
2. Public awareness mainly to focus on women of childbearing age on early prenatal care.	X			
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
On-going screening with the OBGYN being seen and examined pregnant women early in their first bookings. This is being done to identify any high risk pregnant women in their pregnancies. Early identification of high pregnant women continues to provide service needed based on condition.

Special clinic has been implemented for at risk pregnant women, so that they receive special prenatal care. This is being done to identify further problems and detect early signs/symptoms of further problems that may lead to high risk conditions.

c. Plan for the Coming Year
Continues the present activities so that more pregnant women will be able to access the services. Collaborate and coordinate more with the public health nurses and health assistants to identify any pregnant women during early pregnancy.

State Performance Measure 5: *The number of women who are screened for cervical cancer.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			100	100	100
Annual Indicator	98.1	96.7	17.1	9.9	20.2
Numerator	1431	1596	1970	1153	2351
Denominator	1458	1650	11547	11594	11642
Data Source					Health Planning.
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	30	35	40	45	50

a. Last Year's Accomplishments
In 2008, data has shown the there is an improvement, but at the same time, more efforts need to put on this to further improve.

During 2008, a total of 2,351 women have been screened for cervical cancer, compare to 2007, which was 1,153.

Counseling on the importance of annual cancer screen and follow-up are being provided at the MCH clinics, family planning clinic, expanded MCh clinic sites, and in the outer islands during the RH staff visit with the MOH Mobile team to those atolls and islands. Education on the importance of annual/regular pap-smear test, including on how to perform self-breast exams.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Outreach into the community, especially towards the women of childbearing age to educate them on cervical cancer.			X	
2. Educating the women of childbearing age on importance of o have an annual pap smear test.			X	
3. Provide pap smear screening during prenatal 1st visit, outreach trips to the outer islands.			X	
4. Follow-up of clients with the zone nurses.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current Activities:
1. Pap smear test during the first visit for all pregnant women attending prenatal clinics continues.
2. Providing cancer screening during women's health clinics, and provide cancer screening during outreach visits to the outer islands by the public health teams.
3. Activities in regard to educating the child-bearing women ages on issues concerning cancer in women, including cervical cancer are being carried out on all clinic sites.
4. Provide counseling on breast cancer and how to do perform self-breast exam.

c. Plan for the Coming Year

Planned Activities 2010: The MCH/CSHCN program will review/revise its protocol on cancer screening paticularly on cancer of the uterus and cervix. Pap smear screening will be conducted to its implementation in all public health clinics during outreach clinics and trips to the outer atolls. All necessary supplies will be purchased for the screening. Identified women who will need follow-up will be referred to the zonal for follow-up.

State Performance Measure 6: *Proportion of children who are identified and referred to the Children with Special Health Care Needs program*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		395	435	445	461
Denominator		395	435	445	461
Data Source					MCH program survey.
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Accomplishment: During the FY'08 , there are 16 new cases identified and services are being provided. Better coordination and collaboration between MOH and MOE in providing services for these children and their families based on the needs. There is an improvement in communication between these two ministries, parents/clients, community and the service providers with the re-establishment of the Council for Children Special Health Needs and they meet on quarterly basis.

The RMI Advidory Council Children with Disalities consists of, Ministry of Education/Sp.Ed., Ministry of Internal Affairs, Parents, Clients, Ministry of Health, Local Government, Community Representatives, Churches, NGOs.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of screening element/mechanism to identify child with special health care needs.	X			
2. Monitoring services as stated in the MCH protocol for CSHCN so that these children can recieve the care needed.	X			
3. On-ste training for the health care providers on issues concerning CSHCN.	X			
4. Outreach activities such as home visits, zonal, outer islands and screening for CSHCN.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue to provide routine screening for all new born at the public health clinics at six weeks after delivery to identify children with special health needs. Continue to coordinate with the Outer Islands Health Care System for referral of children with special health care needs to the MCH/CSHCN program. Coordinate and collaborate with the health assistants on the outer islands, schools and parents the report or refer any child found to have any unusal conditions/or disablled.

c. Plan for the Coming Year

Develop and implement a tracking system for CSHCN for better data collection for better clients' follow-up, monitoring and evaluation.

Hire new MCH staff, one service coordinator and one staff so that the CSHCN services would improve and also the level of care for these children would be better.

State Performance Measure 7: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective			80	85	85
Annual Indicator	87.1	77.9	82.6	82.6	85.3
Numerator	1842	1643	1743	1743	1800
Denominator	2115	2110	2110	2110	2110
Data Source					MOH
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

Dental was able to provide to Sealant in schools with the total number of 1,800 during 2008. Dental staffs visited the schools every year to provide sealant to students in 3rd grade. Aside from Dental regular clinics and outreach to the schools, an MCH oral health service has been implemented, that includes, prenatal care, well baby clinic, and special education, which dental provided dental service for 72 special education students in 2008.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Dental services is an on-going into the schools.			X	
2. Schools Sealent Program for both public and private schools.			X	
3. Health education is being provided during visiting the school and outreach clinics by the dental staff.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continues to increase the number of student receive sealant in the schools by improving the outreach into the schools. Continues this activity on regular basis and to include more schools. Continues to provide health education on oral health, including prevention aspects of it.

c. Plan for the Coming Year

Strengthen and continues to expand the dental outreach activities to includes more schools, and the community at large.

E. Health Status Indicators

Introduction

The Republic of the Marshall Islands (RMI) projected population for 2006 is 65,814. After reviewing of RMI data, it was found that migration has the single biggest impact growth in the RMI, as we can see from international migration statistics for the RMI, 1990-2006, that recently became available and which have not factored into any projections in the 1990's. This is the reason why our projection provide you with a RMI populaiton total of around 52,338, up-date for 2007 which is lower than the figures of 62,000 currectly floating around.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	12.4	13.2	13.0	12.9	13.8
Numerator	188	214	205	206	210
Denominator	1512	1625	1578	1591	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
2008: The number of live births weighing less than 2,500 grams was slightly increased. Part of the increased was due to pregnant women coming from the outer islands to Majuro, and Ebeye for delivery, as well as those entry into prenatal late. Plan has developed to increased public awareness for childbearing age not just for Majuro, but for Ebeye and the outer islands. Counseling is not just done in the dispensaries during outreach to the underlying community, but house to house is being implemented, hopping that we will be able capture more childbearing women to receive information on importance of early prenatal care.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	10.9	12.6	12.7	12.8	13.0
Numerator	172	204	200	204	199
Denominator	1584	1625	1578	1591	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
2008: Data shows that there is an improvement in decreasing the number of singleton births weighing less than 2,500 grams, but still need to improve. Conseling on nutrition in pregnancy and early prenatal care is being provided in both the base clinics and outreach clinics.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.9	1.7	0.9	0.8	1.2
Numerator	13	28	14	12	18
Denominator	1512	1650	1578	1591	1526
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
2008: There is an increased in live births weighing less than 1,500 grams, and this due to either late entry into prenatal care or coming for delivery in the centers from the outer islands. Activities are being carried, please refer to activities provided HSI 01A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.6	1.7	0.8	0.7	0.9
Numerator	9	28	12	11	14
Denominator	1486	1650	1578	1591	1526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
In 2008, the number of live singleton births weighing less tahn 1,500 grams is slightly higher. It is believe that this is due to pregnant women coming to give birth on the two urban centers of Majuro and Ebeye, and some due to young mothers, and those do not attend prenatal care early in their 1st three months of pregnancy. More effort has been taken into increase our outreach activities to provide counseling, early prenatal care, nutrition in pregnancy, and other issues on prenatal and onward after delivery.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	15.3	9.5	4.7	23.2	18.3
Numerator	5	2	1	5	4
Denominator	32654	21161	21361	21597	21839
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

2008: Data has shown that there is an improvement , but at the same time data also shows that still needs for improvement is highly needed. Activiites have taken place, such as more coordination and collaboration between MOH and Ministry of Public Safety to ensure that laws are followed or car seatbelt is used while driving, and workshops conducted for parents with issues/information on child safety.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	15.3	9.5	4.7	18.5	9.2
Numerator	5	2	1	4	2
Denominator	32654	21161	21361	21597	21839
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
The denominator for FY 2007 is slightly lower than 2006 because of the new RMI total population figure.

Narrative:
2008: Data has shown that there is an improvement , but at the same time data also shows that still needs for improvement is highly needed. Activiites have taken place, such as more coordination and collaboration between MOH and Ministry of Public Safety to ensure that laws are followed or car seatbelt is used while driving, etc.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	30.4	7.8	0.0	0.0	0.0
Numerator	5	1	0	0	0
Denominator	16429	12800	12783	12761	12681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
2008: Data has shown that there is an improvement , but at the same time data also shows that still needs for improvement is highly needed. Activiites have taken place, such as more

coordination and collaboration between MOH and Ministry of Public Safety to ensure that laws are followed or car seatbelt is used while driving, etc.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	44.9	94.3	112.4	217.6	64.1
Numerator	5	20	24	47	14
Denominator	11147	21200	21361	21597	21839
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
Data has shown that there is improvement, but still needs to improve. Staff has taken steps to further improve this area, such as more community health education, and school health program, and parenting skills. Data sources are Majuro Hospital and Ebeye Hospital.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	15.3	18.9	18.7	23.2	13.7
Numerator	5	4	4	5	3
Denominator	32654	21200	21361	21597	21839
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Data 2006.

Narrative:
This shows improvement, staff has put more effort in providing counseling on safety in coordination and collaborating with public safety and schools administrations. Data sources are Majuro Hospital and Ebeye Hospital.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	30.4	23.4	39.1	15.7	15.8
Numerator	5	3	5	2	2
Denominator	16429	12802	12783	12762	12681
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Based on 2006.

Narrative:
RMI remains at 2 vehicle accident among youth aged 15-24. Accident is caused by speeding or alcohol related. Public safety enforced the law on driving under the influence of alcohol and seatbelt law.

Data sources are Majuro Hospital and Ebeye Hospital.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	2.2	169.2	13.0	2.8	5.8
Numerator	19	44	43	9	18
Denominator	8822	260	3304	3189	3083
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Test is available in Majuro Hospital only.

Notes - 2007
Test is available in Majuro Hospital only.

Notes - 2006
Test is available in Majuro Hospital only.

Narrative:
2008: There has an increased in cases, because the program is doing more screening for this age in both base clinics, expanded clinics and outer islands outreach. More teenagers this age have more access to the services without charge. Treatments are being provided at clinics sites and referred for follow-up from Public Health.

For Outer Islands Outreach activities, samples are collected and tested in Majuro Hospital Laboratory.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	10.3	144.9	12.3	2.4	4.6
Numerator	123	51	101	20	39
Denominator	11972	352	8242	8405	8559
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Test is available in Majuro Hospital only,

Notes - 2007
Testing is available in Majuro Hospital only.

Notes - 2006
Testing is available in Majuro Hospital only.

Narrative:
2008: With the program screening services expanded, the more women we have seen and screened. Aside from the regualr clinics, the expanded clinic sites and outer islands outreach, we offer women's health on a regular basis.

For Outer Islands Outreach activities and expanded clinic sites, samples are collected and tested in Majuro Hospital Laboratory.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1526	0	0	0	0	1526	0	0
Children 1 through 4	6222	0	0	0	0	6222	0	0
Children 5 through 9	7196	0	0	0	0	7196	0	0
Children 10 through 14	6895	0	0	0	0	6895	0	0
Children 15	6319	0	0	0	0	6319	0	0

through 19								
Children 20 through 24	6362	0	0	0	0	6362	0	0
Children 0 through 24	34520	0	0	0	0	34520	0	0

Notes - 2010
EPPSO don't have population by race. Pacific Islander is the major race in this population. For population less than 1 year, I based it on the live birth of 2008.

EPPSO don't have population by race. Pacific Islander is the major race in this population.

EPPSO don't have population by race. Pacific Islander is the major race in this population.

EPPSO don't have population by race. Pacific Islander is the major race in this population.

EPPSO don't have population by race. Pacific Islander is the major race in this population.

EPPSO don't have population by race. Pacific Islander is the major race in this population.

Narrative:
HSI 06A: MOH will work with EPPSO in this area, since data is not available, hopefully we will be able provide report in the next cycle.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	1526	0	0
Children 1 through 4	6222	0	0
Children 5 through 9	7196	0	0
Children 10 through 14	6895	0	0
Children 15 through 19	6319	0	0
Children 20 through 24	6362	0	0
Children 0 through 24	34520	0	0

Notes - 2010

Narrative:
HSI 06B: MOH will coordinate with EPPSO to this, since RMI data is not available, hopefully up-date will be able to provide next reporting cycle.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY	**Total**	**White**	**Black or**	**American**	**Asian**	**Native**	**More than**	**Other and**

Total live births	**All Races**		**African American**	**Indian or Native Alaskan**		**Hawaiian or Other Pacific Islander**	**one race reported**	**Unknown**
Women < 15	4	0	0	0	0	4	0	0
Women 15 through 17	79	0	0	0	0	78	1	0
Women 18 through 19	170	0	0	0	0	167	3	0
Women 20 through 34	1149	2	0	0	9	1118	20	0
Women 35 or older	124	0	0	0	1	122	1	0
Women of all ages	1526	2	0	0	10	1489	25	0

Notes - 2010
EPPSO can't provide population by race.

EPPSO can't provide population by race.

EPPSO can't provide population by race.

Narrative:
HSI 07A: Data is not available, but MOH will coordinate with EPPSO for date for coming reporting cycle.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	4	0	0
Women 15 through 17	79	0	0
Women 18 through 19	170	0	0
Women 20 through 34	1149	0	0
Women 35 or older	124	0	0
Women of all ages	1526	0	0

Notes - 2010

Narrative:
HSI 07B: Data is not available, MOH will work with EPPSO for data and up-date will be provided in the next cycle.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	47	0	0	0	0	47	0	0
Children 1 through 4	9	0	0	0	0	9	0	0
Children 5 through 9	3	0	0	0	0	3	0	0
Children 10 through 14	2	0	0	0	0	2	0	0
Children 15 through 19	4	0	0	0	0	4	0	0
Children 20 through 24	4	0	0	0	1	3	0	0
Children 0 through 24	69	0	0	0	1	68	0	0

Notes - 2010

Narrative:
HSI 08A: Data on this is not available, and MOH will coordinate with EPPSO since this is the RMI National Data/Planner.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	47	0	0
Children 1 through 4	9	0	0
Children 5 through 9	3	0	0
Children 10 through 14	2	0	0
Children 15 through 19	4	0	0
Children 20 through 24	4	0	0
Children 0 through 24	69	0	0

Notes - 2010

Narrative:
HSI 08B: MOH will provide an up-date in the next cycle, since data is not available yet.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	28158	0	0	0	0	0	0	28158	2008
Percent in household headed by single parent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid		0	0	0	0	0	0	0	2008
Number enrolled in SCHIP		0	0	0	0	0	0	0	2008
Number living in foster home care		0	0	0	0	0	0	0	2008
Number enrolled in food stamp program		0	0	0	0	0	0	0	2008
Number enrolled in WIC		0	0	0	0	0	0	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008

Notes - 2010
Data is not available in EPPSO.

Not applicable for RMI.

RMI don't have Medicaid.

RMI don't have SCHIP.

We don't have food stamp program in RMI.

Narrative:
HSI 09A: MOH will coordinate with EPPSO for data concering this and will give an up-date in the next cycle.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	28158	0	0	2008
Percent in household headed by single parent	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	0.0	2008
Number enrolled in Medicaid	0	0	0	2008
Number enrolled in SCHIP	0	0	0	2008
Number living in foster home care	0	0	0	2008
Number enrolled in food stamp program	0	0	0	2008
Number enrolled in WIC	0	0	0	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	2008

Notes - 2010

Narrative:
HSI 09B: MOH will provide up-date on data in the next cycle. MOH will coordinate with EPPSO regarding this HSI.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	0
Living in urban areas	28158
Living in rural areas	0
Living in frontier areas	0
Total - all children 0 through 19	28158

Notes - 2010
RMI does not have or used metropolitan areas, instead, Rural, Urban, and Outer Islands are being used as for the country population distribution.

RMI does not used fromtier areas, instead, Rural, Urban, and Outer Islands are being used as for population destribution.

Narrative:
2008: RMI is divided into the two Urban center of Majuro as the capital of the Republic of the Marshall Islands and the rural atolls and islands of the nations (outer islands).

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	53305.0
Percent Below: 50% of poverty	2.0
100% of poverty	56.0
200% of poverty	70.0

Notes - 2010

Narrative:
Based on the Federal guideline on plverty level, almost 100 is below this guideline.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	28158.0
Percent Below: 50% of poverty	45.0
100% of poverty	100.0
200% of poverty	100.0

Notes - 2010

Narrative:
Based on Federal Poverty level, the age 0-19 is below this poverty level.

F. Other Program Activities

/2009/ The MCH/CSHCN Program is already a program area within Public Health. The nurses and medical staff in Public Health provide other preventive services in STD, family planning, non-communicable diseases, immunization,TB and leprosy as well. The MCH coordinator is member of the MOHE Core Committee which coordinate all community awareness activities. The MCH program is also a member of the RMI Inter agency Council meets regularly to ensure continuous services is provided to all CSHCN, both in school and those who are not. The Breast Feeding Policy Committee also actively work closely with the MCH program and services in community awareness activities on nutrition and breast-feeding. The MCH program will participate fully in all community awareness and training programs preventive services to women, children, infants, youths and their families. //2009//The MCH/CSHCN Program has being integrated into Division of Reproductive Health. The RH nurses and medical/OBGYNs in Reproductive Health provide other preventive services in STDs, family planning, non-communicable diseases, immunization, TB, and leprosy as well.
/2010/ No change. //2010//

G. Technical Assistance

/2009/ The MCH/CSHCN program will need TA in the areas specified in the the Form 15. There are weakness in the area in the program reporting system. Data System Development and performance Indicators. TA is also essential in the evaluation for the CSHCN to ensure services provided and mechanisms for screening are implemented. //2009//The MCH/CSHCN program is in need for TA in the areas specified on Form 15. Program for tacking of clients is highly need at the point to be able make a better assessments for better service follow-up, monitor, and evaluation of program clients.

V. Budget Narrative

A. Expenditures

/2009/ For FY 2006, the RMI spent 100% of its MCH funds. Forty five percent of the total grant award is for personnel. of the total funds for non-personnel, the RMI spent 25% on direct health care, 13% in enabling services and 7% on infrastructure building services. The allocation of the administration cost utilized 10% if its allocation. //2009//In FY 2007 the RMI MCH/CSHCN spent the MCH Block Grant fund based on the components and 30-30-10 percents accordingly.

B. Budget

/2010/ Annual Budget and Budget Justification: The Block Grant funds will be used to provide and coordinate routine preventive and primary health care for mothers, infants, and children. The scope of these services includes prenatal care, including special high risk prenatal clinics; postpartum care; well baby care, including immunization; high risk pediatric clinics; school health programs; coordination of family planning services; and provision or coordination of care for children with special health care needs. //2010//

/2010/ To identify children with special health care needs, initial screening of children will be perform by public health nurses at the Majuro and Ebeye Hospitals and by health assistants at the outer island dispensaries. //2010//

/2010/ The Title V funding will be used to support the short term services of specialized consultants to work with children identified as having special health care needs. The specialist will be brought to the Marshall Islands to perform surgery on such children, that may include, plastic surgery and pediatric cardiology (these services are not available on island). The program will also arrange and pay for those children with special health care needs that may need to refer overseas for further medical care that are not available on island (the program pay plane tickets and stipend at while receiving medical care off islands for 2 weeks only, otherwise, the RMI Government will carry on the stay will require beyond two weeks). //2010//

Administrative Costs:

/2010/ The RMI Government of has chosen to combine the administrative costs for all components of the project into a single comprehensive category for administering the block grant funds For the past decade, the RMI Government has consistently applied this approach to the administrative costs associated with the Maternal and Child Health Block Grant projects. //2010//

Administrative Cost $25,249
A. Personnel $ -0-
B. Fringe Benefits $ -0-
C. Travel $ 5,041
D. Equipment $ 18,000
E. Supplies $ 1,208
F. Contractual Services -0-
G. Other $ 1,000

A breakdown of the MCHB is provided here according to the three component of the grant Budget justification follows under.

Component A: Pregnant Women, Mothers and Infants $75,748
A. Personnel $ 26,795
B. Fringe benefits $ 2,763.16

C. Travel $ 15,500
D. Equipments $ 20,000
E. Supplies $ 2,000
F. Fuel $4,190
G. Communication $2,500
H. Other Cost (program vehicle maintenance, etc.) $2,000

Component B: Children & Adolescents $ 75,748
A. Personnel $ 54,125
B. Fringe benefits $ 4,330
C. Travel $ 5,500
D. Equipment $ 2,000
E. Supplies $ 1,000
F. Contractual Serv. $ 500
G. Others $ 500

Component C: Children with Special Health Care Needs $ 75,750
A. Personnel $ 14,700
B. Fringe Benefits $ 1,176
C. Travel $ 39,677
D. Equipment $ 7,600
E. Supplies $ 3,521
F. Contractual $ 6,900
G. Printing/Reproduction $1,176
H. Other $1,000

Administrative Cost $ 25,249
MCH Budget(State Federal Allocation) $252,495

MCH Budget(Federal and State Block Grant Partnership) $441,867
Total budget for FY 2005 $1,614,891

3.1.1 Completion of Budget Forms

Detailed budget breakdowns are found in Forms 2,3,4,and 5

3.1.2 Other Requirements

For the FY 2006 budget, 48% is for salaries of personnel who provided direct services for the MCH/CSHCN program. There are 7 personnel under the MCH/CSHCN program. However, other health personnel in Public Health also provided direct health care services to the MCH population as well.

Although travel costs allocated account for 19% of the total budget for FY 2005, this allocation support the goals of the Ministry to improve preventive and primary health care services for the targeted outer islands population in MCH. Traveling within the Marshall Islands is necessary for personnel to provide health care services in support of the health assistants in the health centers. Furthermore, the identified CSHCN will need to travel to and from their own islands to the urban center for follow-up and further treatment and follow-up to Honolulu Shriners' Hospital for Children if necessary.

State Match

The total for the MCHBG application for FY 2010 is $252,495. This amount is based on the Marshall Islands' FY 1989 Maintenance of Effort Amount of 175,745. The State Match for the MCH grant application is $189,372.

Documentation of Fiscal Restrictions

The Republic of the Marshall Islands assures the Secretary of Health and Human Services that no more tha 10% of the Title V funds will be used for administrative cost for the MCH Block Grant. The total amount will be used by the MOH Administration to: 1) attend meeting that are conducted by the MCHB and other agencies with regards to the MCH Programs and Services, 2) purchase supplies that are needed for administrative support of the MCH services such as office supplies, stamps, and other means to support communication between the funding agencies and the MOH, and 3) contractual services that are needed for the regular maintenance of office equipment used by the MOH Administration.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.